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West Virginia Medical JOURNAL

Volume 95 No. 1 West Virginia State Medical Association January/February 1999

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Seminars

Type II Diabetes: A Primary Care Approach
Wednesday, January 27, 1999
12:30 p.m. to 5:30 p.m.
(Afterwards a limited number of tickets will be available for the WVU vs. Marshall University basketball game, registration is required.)

Cardiology Conference at Snowshoe (with the American College of Cardiology)
February 1, 2 and 3, 1999
Mountain Lodge Conference Center
Snowshoe, WV
William Carter, MD

OB/GYN Update: A Pre-conference for the Family Physician
Thursday, April 22, 1999
5 to 9 p.m.
Charleston House Holiday Inn
Charleston, WV
E. Reed Heywood, MD
Program Chairman

26th Annual Newborn Day: Hematology Disorders of the Newborn
Friday, April 23, 1999
7:30 a.m. to 4:30 p.m.
Tamarack, Beckley, WV
Stefan Maxwell, MD
Program Chairman

Issues in Medical Ethics
Wednesday, June 9, 1999
8 a.m. to 5 p.m.
Tamarack, Beckley, WV
Robert T. Hall, PhD
Program Chairman

On-Site Continuing Education Outreach Programs

Chemical Hazards in the Kanawha Valley
February 3, 1999, 12:30 p.m.
Montgomery General Hospital
Montgomery, WV
Bipin Avashia, MD

Management and Work-Up of Anemia
February 17, 1999, 6 p.m.
Man ARH, Man, WV
Steven Jubelirer, MD

New Innovations in Cardiovascular Surgery
February 25, 1999, 5:45 p.m.
Tamarack, Beckley, WV
John Chapman, MD

Common Presentations of Acute Leukemia
March 3, 1999, 12:30 p.m.
Montgomery General Hospital
Montgomery, WV
Richard Williams, MD

Gynecology in the Next Millennium
March 9, 1999, 6 p.m.
Plateau Medical Center
Oak Hill, WV
Paul Fulcher, MD

Renal Transplantation Update
March 12, 1999, Noon
Logan General Hospital
Logan, WV
Lawrence Wyner, MD

Dare to Care
March 16, 1999, 6:30 p.m.
Roane General Hospital
Spencer, WV
Joseph T. Skaggs, MD
Robin C. Rector, MA

Wound Care Management, Part II
March 17, 1999, 6 p.m.
Man ARH
Man, WV
Scott Spradlin, DO

Diagnosis and Treatment of Ovarian Cancer
March 23, 1999, 5:45 p.m.
Days Inn and Conference Center
Flatwoods, WV
Michael Schiano, MD

Common Foot Problems
April 5, 1999, 12:30 p.m.
Montgomery General Hospital
Montgomery, WV
Scott Glassburn, DPM

Prevention of Medication Errors
April 13, 1999, 6 p.m.
Plateau Medical Center
Oak Hill, WV
Jeff Hess, PharmD

Black Lung Evaluation
April 21, 1999, 6 p.m.
Man ARH
Man, WV
James Walker, MD

Geriatric Trauma
April 26, 1999, 5:45 p.m.
Café Acropolis
Summersville, WV
Frank C. Lucente, MD

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West Virginia Medical JOURNAL

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A black bear cub in Upshur County.

Photo courtesy of Stephen J. Shaluta Jr., West Virginia Department of Commerce.

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Manuscript Guidelines

All articles for the *West Virginia Medical Journal* must be submitted on an IBM compatible disc. Wordperfect 5x, Wordperfect 6.0/6.1, Microsoft Word for DOS, and other languages are acceptable. If the manuscript contains tables, the main body of the manuscript and references should be saved as one item, i.e., *article*, and then each table should also be saved as a separate item, i.e., *Table 1, Table 2.*

All scientific manuscripts should be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."* Papers will not be considered for publication if they have already been published or are described in a manuscript submitted or accepted for publication elsewhere. All persons designated as authors should have participated enough in the work to take public responsibility for the concept.

Manuscripts should be accompanied by one extra copy, be double-spaced, have each page numbered and should include a title page, an abstract of no more than 150 words, and references numbered consecutively. No more than 10 references will be published and then a statement will appear that the author should be contacted for the other references listed in the manuscript.

Tables, figures and photos should be numbered, and indicated with parentheses whenever they are mentioned in the text, i.e. (Table 1), (Figure 1). Legends should be included for all figures and photographs.

Photos must be unmounted glossy prints in a 5 x 7 format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author at a cost of $13 for each photo. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be created in black and white.

All scientific material is reviewed by the editor and three members of the Publication Committee. Depending on their content, other types of articles are usually only reviewed by the editor and should still be mailed to the same address. All articles should be addressed to: Stephen D. Ward, M.D., Editor, *West Virginia Medical Journal*, Charleston, WV 25364.

If you have questions or need more information, phone Nancy L. Hill, managing editor at (304) 925-0342.

President's Page

Great Expectations . . . No, not the Charles Dickens novel

As I write this article, we have just begun a new year filled with hope, anticipation and Great Expectations of what we want to accomplish in 1999. Most of us are hoping to make a difference, make an impact, and make our mark.

Since August, your West Virginia State Medical Association officers have been very busy laying the groundwork for the completion and fulfillment of the goals we set out to accomplish. As I travel throughout the state and visit with members, I am constantly amazed at just how enthusiastic and helpful you are about working with your state and county societies to try and make a difference. With this thought in mind, we have been meeting with legislators and leaders of other health care organizations to mend fences and build bridges. I am pleased to report that many positive steps have been made.

The WVSMA is eagerly awaiting the results of the very comprehensive malpractice survey each of you were mailed and were asked to complete. The data from this survey will help us to show legislators that reform is well past due.

There is no question the Physician Provider Tax must go, but it won't be eliminated until the money generated by the tax can be replaced. Yes, the provider tax is unfair but the question remains the same — what money will replace the millions collected from physicians? Until there is an answer, this battle will be ongoing.

The multitude of issues with PEIA cause a lot of concern. We all know you cannot keep offering everything without someone having to pay. Rising premiums, lower reimbursements, fewer choices — all have bad connotations to everyone. The solutions will be difficult, but we are there helping to create or prevent changes. Our goal is to continue working toward common sense solutions. This could include cafeteria-style plans with the employee deciding what they want, or treating in-state and out-of-state providers the same.

In our continuing efforts to better serve the members of the WVSMA, we have re-activated the Insurance Committee. This committee's goal is to compare insurance companies, examine policies and provide information. We cannot let our members be caught in the demise of another malpractice company.

We are also working to change the joint and several liability laws to make them more reasonable and to help protect our families and our lives. In addition, the Alliance is in the forefront with the issue of domestic violence, but they need help from the entire membership.

As you can see, we have many issues and little time. Please join us in the effort. I would encourage each of you to do more than just ride the wave, be the wave. Plan to close your office for the day and participate in our statewide Legislative Day, scheduled for Jan. 21 in Charleston. Talk with your local legislators, attend the WVSMA's Legislative Reception, be informed and make a difference.

Finally, two quotes from columnist Dave Berry that seem to put all of these thoughts into perspective — *"The most valuable function performed by government is entertainment,"* and *"No matter what happens, somebody will find a way to take it too seriously."* A sad, but sometimes true, commentary.

We all need to push hard but enjoy our life so we can reach for our "Great Expectations" (1).

David W. Avery, M.D.

1. A novel by Charles Dickens usually read in high school, which probably gave us our first experience with Cliff Notes.

Benevolence

A news item reports that Oregon's system of rationed health care for low income citizens is in trouble. That system attempts a reasonable and logical effort at defining what might be cost effective in medical care and which might produce a cost benefit ratio acceptable to the taxpayers of Oregon.

The system sets a priority list of medical procedures with the top items on the list those leading to a quick response for the most commonly encountered conditions. The bottom of the list might be procedures such as cosmetic surgery and organ transplants. The insurance is provided for those not covered in any employer health plan and to others deemed as having insufficient income to purchase available health insurance. The whole idea is refreshingly innovative in that it approaches health care rationing in an open and honest manner by informing any interested party what the exact limits of the coverage are . . . somewhat different from the usual HMO routine of promising everything known to medical science until the hapless subscriber gets sick.

It is perhaps reassuring to West Virginians to learn that there are also poor people in supposedly rich states such as Oregon and that even these states have difficulty paying their medical bills. It is noted in the news item that in the spirit of their kindness and generosity Oregon officials have expanded the scope of their plan during the past year to include physician assisted suicide and are considering adding sex change operations this year. We can appreciate the possible economic benefits of killing off sickly subscribers before they run up large medical bills, but the benefits to the plan or to the economy as a whole through the provision of sex change operations escapes us. The welfare mentality, however, seems perfectly clear and the reason for the plan's current difficulties perfectly obvious.

West Virginians in the past have taken a back seat to no one in matters of generosity and kindness, but we hope the competitive fires of West Virginia welfare officials are not stirred in any lately conceived contest. Oregonians, however, propose to pay for their benevolences by increasing taxes to pay for the new benefits while West Virginia welfare officials continue to thrust the burden of payment for their generosities onto the physicians of this state through a gross receipts' tax levied exclusively on physicians and dentists.

Members of our Legislature and officials of the Welfare Department smile graciously as they accept plaudits for their blessed charity. West Virginia physicians can only groan at the sight.

Stephen D. Ward, M.D.
Editor

Special AMA Delegation Report

The AMA House of Delegates met in Honolulu from December 5-9. Your delegation attended and participated in all sessions of the House and Reference Committees. Approximately 250 pieces of business came before the House. The following is a summary of some of the most important issues:

- The House vigorously debated the report of the of the Ad Hoc Committee on Governance. This report stemmed from the controversy surrounding the SunBeam matter and how flaws in AMA structure allowed the fiasco to happen in the first place. The committee's report was 28 pages long and produced 36 separate recommendations. In summary, the Board of Trustees will now operate differently. The chair of the board will be responsible for fiduciary issues and direct the executive vice president on business matters. The president of the AMA will be the main spokesperson for the Associaton. No longer will the chair of the board automatically ascend to to president. This eliminates the burden on the chair to be a "political" figure. A strategic plan will be created to form a blueprint for the organization. This will allow the AMA to be proactive, not just reactive. The report also contained many other recommendations regarding staff structure, House function, and Board function. The entire house supported this endeavor with considerable enthusiasm. This single issue consumed about 10 hours of debate time.

- The House also approved the formation of a task force of leaders in medicine to examine and recommend ways to change and strengthen the federation of medicine. Organized medicine is facing an increasingly competitive environment. The goal of this task force is to make the AMA more efficient and relevant in a future that challenges the motivation for physician membership. It has the potential to be one of the most important turning points for the AMA and may actually become a watershed for the next generation of physicians.

- E & M documentation guidelines were extensively discussed. Seven different resolutions were reviewed and debated. From this, the House established language condemning the government's characterization of good faith medical practice as fraud. The House also asked the AMA to deal with HCFA as strongly as possible to settle the E & M coding controversy. Debate was forceful and unified.

- In regard to continuing medical education, the House approved the ACCME's new System98. This new system of accreditation and recognition by the ACCME should actually make the process of accreditation much easier. The West Virginia State Medical Association has had the opportunity for input on this new system. We feel fully prepared to make the change without any significant disruption.

- The Tobacco Industry Master Settlement Agreement was debated in great detail and at great length. The House approved language calling on the AMA to undertake action to promote the use of settlement funds for prevention, education, research and medical services. The AMA is also to work for enhanced funding for medical services over and above current Medicaid funding levels.

- Your WVSMA delegation at I-98 consisted of the following individuals:

Delegates

Constantino Amores, M.D.
James Helsley, M.D.
John Holloway, M.D.
Michael Fidler, M.D.

Alternate Delegates

Stephen Sebert, M.D.
Stephan Thilen, M.D.
Alva Deardorff, M.D.

WVSMA President

David Avery, M.D.

WVSMA Council Chairman

Thomas Chang, M.D.

Young Physicians

Dorian Williams, M.D.
Joseph Selby, M.D.

American Academy of Otolaryngologic Allergy

James Bryant, M.D.

American College of Radiology

Ronald E. Cordell, M.D.

WVSMA Staff

Nancie Albright
Tim Allman

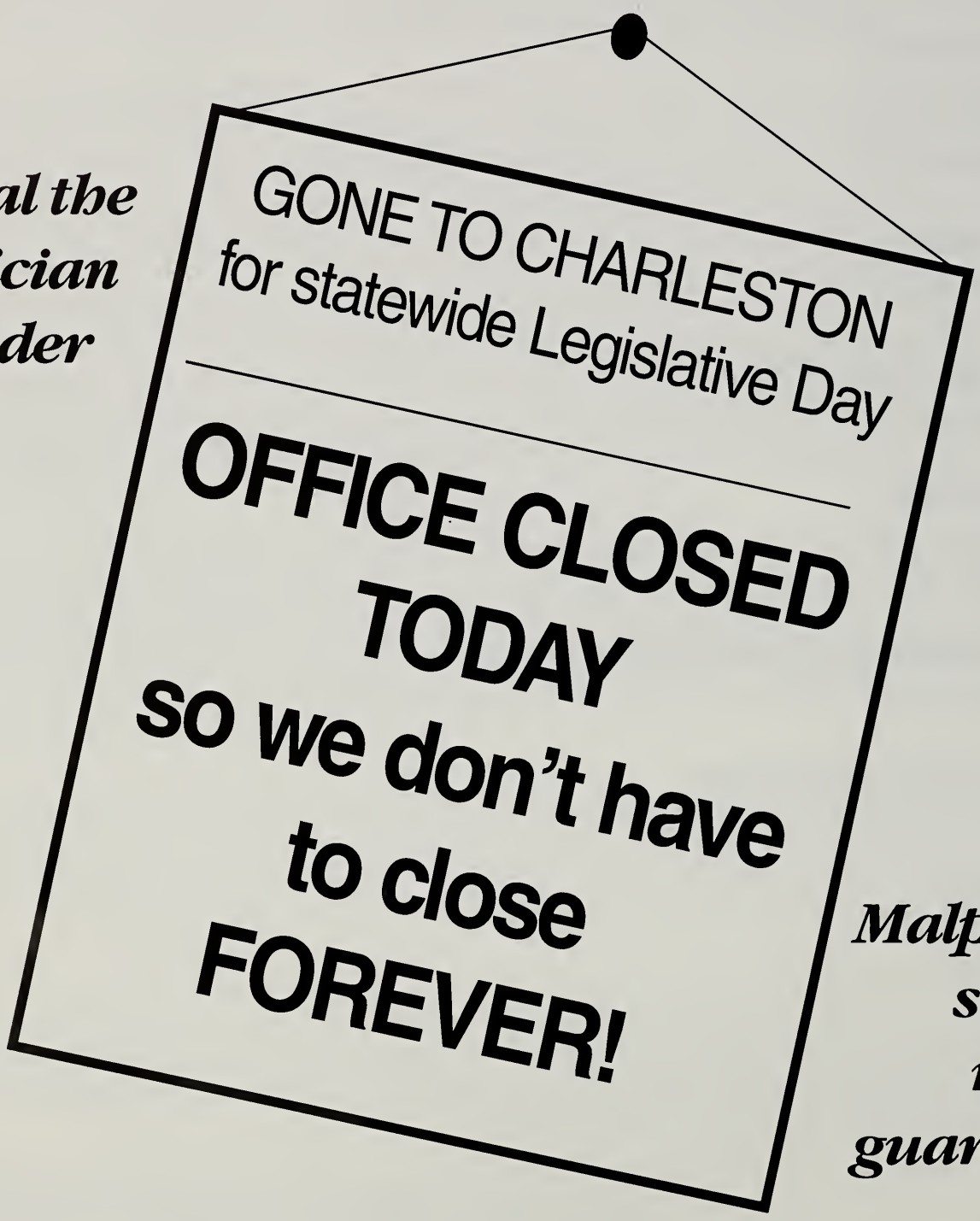
The entire West Virginia delegation appreciates the support of the membership of the WVSMA for making it possible for them to attend AMA meetings. Any of the above individuals would be delighted to discuss AMA issues with any member of the WVSMA.

Constantino Y. Amores, M.D., AMA Delegation Chairman
James D. Helsley, M.D., AMA Delegate

Mark your calendar now...

January 21 is WVSMA Legislative Day

Repeal the Physician Provider Tax!



Malpractice solvency must be guaranteed!

Look for this flier in your mailbox soon. Then, make a statement by posting it on your office door and joining with us Jan. 21 as physicians from around West Virginia converge at the state capitol to make their concerns known.

You are cordially invited to attend our

Legislative Reception

Thursday, January 21, 1999

6:30 p.m. - 8 p.m.

Embassy Suites Hotel, Grand Ballroom

Charleston, West Virginia

Please R.S.V.P. by January 18, 1999

(304) 925-0342 or (800) 257-4747

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Special Article

Release records and manage confidentiality?

Q. I'm worried I may release a patient's record without taking the correct actions to protect myself and my patient's confidentiality. Are there proper guidelines I should abide by when releasing records to third parties? What, if any, precautions can I take when asked to produce a patient's record? Also, how long should I keep a patient's record on file?

A. It's important for all medical professionals to consider some general guidelines when releasing a patient's record for any reason. The following information may help you in understanding the different types of records and the actions that may be required in releasing them to third parties.

You should **never** release any record unless you have one of the following items: a signed authorization from the patient, a subpoena or a court order.

If you are asked to produce a record to a third party and you have the consent of the patient, you may consider the following guidelines to ensure proper action has been taken to cooperate while still honoring your patient's privacy:

- Review the request for completeness and validity.
- Review the requested record for accuracy and completeness. (If you have any concerns or questions releasing the information, contact the risk management experts at Medical Assurance for guidance and assistance).
- Copy only the requested parts of the record.
- Do not alter the record for any reason.
- Hand deliver the record and obtain a signed receipt for it, or send via registered mail, return receipt requested.
- Finally, place a copy of the court order, subpoena or patient's authorization in the patient's file and document what records were sent and when.

While all information in a patient's medical record is confidential, even stricter rules apply for information that courts consider "privileged." This would apply to any patient record containing psychiatric or psychological, HIV or drug/alcohol treatment information. These records should only be released if you have the patient's specific authorization or a direct court order. Keep in mind, a patient's **general** consent to release or a subpoena **alone** is insufficient for releasing privileged information. If you receive a subpoena from a third party requesting records containing information you consider to be privileged, you should not automatically hand the record over unless the subpoena is accompanied by a signed authorization from the patient. This is a tricky area within the law, and you may want to contact Medical Assurance for risk management assistance and guidance.

Remember, whenever a record is released, clear documentation should be made in the patient's chart with the patient's signed consent and/or the legal document included as well.

As far as the length of time you should keep records, Medical Assurance's legal experts suggest physicians keep office records as long as possible, and certainly outside the limits of the applicable statute of limitations. However, between 15-20 years should ensure you have acted within the appropriate guidelines. Pediatricians and other physicians who treat children may want to consider keeping records even longer.

Physicians insured by Medical Assurance, WVSMA's endorsed professional liability carrier, may contact the company's Risk Resource Center for prompt answers to liability questions by calling (800) 282-6242 or via e-mail at rmhelp@maih.com.

Mark your calendars NOW!!

1999 WVSMA Annual Meeting

August 25-28, 1999

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Watch for topics and speakers for this year's Annual Meeting in future issues of the *West Virginia Medical Journal* and other WVSMA publications.

Pancreas Divisum - The role of ERCP in children

IZZEDDIN KAMELMAZ, M.D.

YORAM ELITSUR, M.D.

Division of Gastroenterology, Department of Pediatrics, Marshall University School of Medicine, Huntington

Abstract

Pancreas Divisum (PD) is the most common congenital anomaly of the pancreas leading to chronic pancreatitis in children. The best diagnostic procedure to establish this diagnosis is Endoscopic Retrograde Cholangiopancreatography (ERCP). Utilizing ERCP as a therapeutic modality (sphincterotomy, stone removal), enables the clinician to improve symptoms and reduce morbidity. In this report, we describe the clinical presentation and outcome of three children with chronic pancreatitis who were subsequently diagnosed with PD by ERCP. We recommend that ERCP should be considered in children with chronic pancreatitis of unknown etiology.

Introduction

Pancreas Divisum (PD) results from an incomplete fusion of the dorsal (Santorini) and ventral (Wirsung) pancreatic ducts and their respective pancreatic tissues during embryologic development (1).

In this anatomic aberration, the major part of the pancreas is drained by the accessory papilla (papilla of Santorini duct), which may be too small to drain the secretion. Anatomic or functional stenosis at the accessory papilla (Santorini duct) may account for the increased incidence of acute or recurrent pancreatitis in these patients who lack an alternate pancreatic outflow.

PD has been observed in 5% -14% of patients in two autopsy studies (2,3). In a previous report, a total of 116 ERCP procedures were performed in children. Abnormal ERCP results were found in 83 children, of whom 14 (16.8%) were diagnosed with PD (4). Utilizing ERCP as a diagnostic modality, PD anomaly was documented in 25.6% of 78 adult patients with idiopathic chronic pancreatitis compared to 3.6% in 169 adults with biliary tract disease who had incidental pancreatography during endoscopic cholangiography (5). These data suggested the etiological role of PD in chronic pancreatitis.

In this report, we review the clinical, laboratory, and imaging studies of three children who were diagnosed with PD. The aim of this study is to alert primary care physicians to this uncommon cause of pancreatitis, and to suggest ERCP as a diagnostic and/or treatment modalities for children with unexplained, recurrent attacks of pancreatitis.

First case report

C. S. is a 16-year old white female with a history of multiple hospital admissions for recurrent abdominal pain, nausea and vomiting. She was subsequently diagnosed with chronic pancreatis.

Her family history was positive for diabetes mellitus and hyperlipidemia. She denied smoking and alcohol consumption. Lab tests showed elevated amylase and lipase with normal liver function tests (Table 1).

Serum cholesterol, calcium, phosphorus, and liver function tests were within normal limits. Abdominal ultrasound and CT scan revealed an edematous pancreas with mild inflammatory changes (Table 2). During ERCP, the ventral duct was found to be irregular. Cannulation of the minor papilla (Santorini duct) confirmed the diagnosis of PD.

Sphincterotomy was performed and a pancreatic stent was placed in the minor papilla. She developed post-ERCP pancreatitis and was admitted for another two days. Pancreatitis resolved with conservative treatment (pancreas rest and analgesia), and she was discharged. The stent was removed five weeks later and pancreatic enzyme supplementation was started.

She was free from symptoms for one year, but developed acute pancreatitis after mononucleosis. She was admitted for a few days and discharged with recommendations for a low-fat diet and pancreatic enzyme supplementation.

Second case report

Z. K. is a 16-year-old male who had first been diagnosed with PD at age 12 after undergoing ERCP.

This patient had a history of multiple admissions for pancreatitis. He had been sent for a therapeutic sphincterotomy, but it had been unsuccessful.

His family relocated to the Huntington area and he was followed at the Marshall University School of Medicine's Pediatric Gastroenterology Clinic. He stayed free of symptoms for three and a half years until ERCP was again performed. During this procedure, the diagnosis of PD was reconfirmed, but cannulation of the minor papilla was unsuccessful and sphincterotomy could not be done. He developed post-ERCP pancreatitis and was admitted to a local hospital.

His family history was negative for diabetes mellitus and hyperlipidemia. He denied smoking or alcohol consumption. Laboratory tests showed elevated amylase and lipase levels with normal liver function tests (Table 1).

After conservative treatment, he recovered and was discharged with pancreatic enzyme supplementation. He later underwent sphinctotomy in a larger medical center with extensive experience in ERCP for children.

Table 1. Laboratory Data on the Three Patients Diagnosed With PD.

	Case 1	Case 2	Case 3
Amylase/lipase	1007/6361	165/499	1100/2200
Hb (g%)	15.7	13.6	14.1
WBC (X1000)	9.1	6.1	7.1
Glucose (mg%)	98	6.1	89
Calcium (mg%)	9.9	6.1	10.5
Alk. Phos. (U/L)	101	193	247
ALT (U/L)	101	20	22
AST (U/L)	20	18	34
GGT (U/L)	24	11	21
Choles. (mg%)	207	148	177

Third case report

J.J. is a 6 ½ year-old white male with a history of abdominal pain, nausea, and vomiting. Initial examination showed abdominal tenderness, mostly in epigastric area. Lab tests showed normal blood counts; serologic tests for EBV, CMV, and Coxsackie viruses were negative.

Abdominal ultrasound revealed cyst formation in the head of the pancreas. Abdominal CT scan and MRI confirmed this diagnosis. A hepatobilliary imaging study revealed no significant abnormality. ERCP showed a normal ventral pancreas, but a complete pancreatic divisum.

In February 1997, he was admitted for acute pancreatitis secondary to chicken pox. Repeated CT scan showed that the pancreatic cyst had decreased in size. He was treated symptomatically and discharged. He did not return for follow up.

Discussion

Pancreas divisum has recently been identified as a common cause of relapsing, chronic pancreatitis in children. Since the introduction of ERCP for diagnosis of chronic pancreatitis, many more cases of PD have been found.

In this report, we describe one child and two teenagers with recurrent symptoms and signs of acute pancreatitis. Extensive lab workup failed to disclose a specific cause. ERCP was the only diagnostic method which identified the congenital pancreatic anomaly.

In experienced hands, cannulation of the biliary tract by ERCP in children is very successful (> 92%), and is very valuable in establishing the diagnosis of PD (4, 6-9). Repeat ERCP attempts, however, are not uncommon. In our patients, repeated attempts were undertaken to cannulate the accessory papilla, and sphincterotomy failed in two patients. These results further emphasize the difficulties of performing ERCP in children.

Since children's bile ducts are smaller, ERCP should be performed only by experienced endoscopists, utilizing appropriate-size instruments.

Table 2. Radiologic Data on the Three Patients Diagnosed with PD.

	Case 1	Case 2	Case 3
Abdominal ultrasound	Edematous pancreas	Edmematous pancreas	Enlarged pancreas with pseudocyst in the head
Abdominal CT	Edematous change with fluid in the periduodenal region	Normal	Cyst in head of pancreas
ERCP	Irregular dorsal	Occuled major duct. Failed sphincteromtomy.	Pancreatic divisum. Failed sphinctermotomy.

Therefore, referral to major medical centers is recommended.

Post-ERCP pancreatitis is the most common complication in adults, with an estimated frequency of up to 15% (10). A review of recent studies in children included a total of 148 ERCP procedures. ERCP-induced pancreatitis was reported in nine of these patients (6%); none were hospitalized (6-9).

Two of our patients developed pancreatitis after ERCP (one performed locally and the other was in a larger medical center). In both cases, hospitalization was necessary, but the pancreatitis was resolved with conservative treatment. In a recent double-blind, multicenter study, prophylactic gabaxate was shown to reduce the severity of pancreatic damage related to ERCP, but no change in abdominal pain or episodes of acute pancreatitis was seen (11). Other reports showed a lower post-ERCP complication after prophylactic steroid treatment (12). It is uncertain if these data apply to children.

Chronic pancreatitis can lead to pancreatic insufficiency. To prevent this development, early diagnosis and intervention are important. Exogenous pancreatic supplementation is one of the conservative methods of treatment in children with chronic pancreatitis. In order to reduce pancreatic exocrine secretion (13), two of our patients received this and remained pancreatitis-free for one year (patient 1) and 2.5 years (patient 2).

Endoscopic sphincterotomy with or without stent placement, is the conservative surgical treatment available for patients with PD. Unfortunately, the long-term assessment of this procedure has not been fully studied. Endoscopic sphincterotomy for stone removal has been previously reported in children and adults (4,7,8,14). To our knowledge, there are no controlled studies which evaluate the efficacy of sphincterotomy with or without stent placement in children with PD. To answer this question, prospective, multicenter studies are clearly warranted.

Conclusion

In summary, we have described three children with recurrent pancreatitis. The diagnosis of PD was established in all three patients by ERCP. Sphincterotomy, stent placement and pancreatic enzyme supplementation are the currently available treatments.

In experienced hands, ERCP is a relatively safe procedure for the diagnosis of PD, and should be considered in children with recurrent pancreatitis of unknown etiology.

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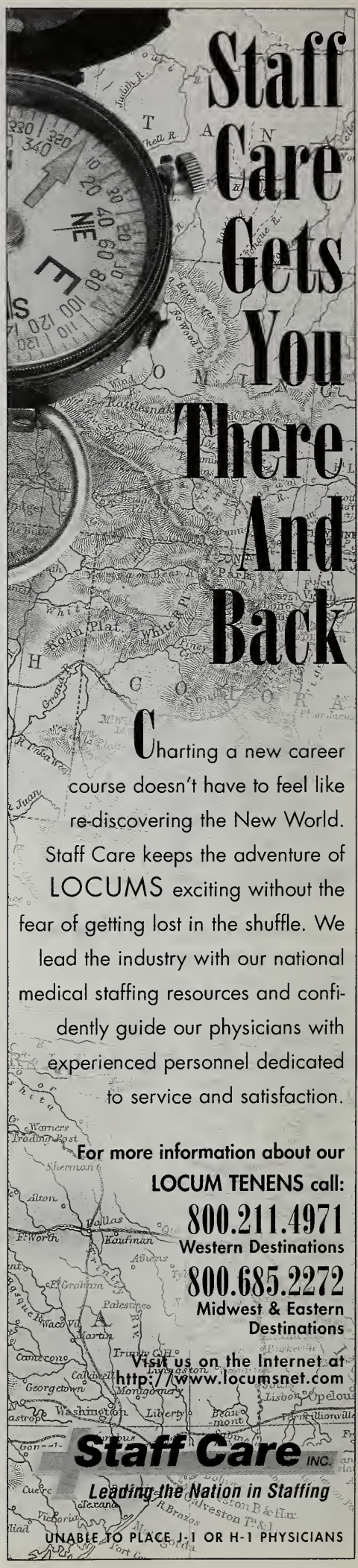

Carotid artery dissection: A challenging diagnosis

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Abstract

Spontaneous extracranial internal carotid artery dissection (ICAD) is a rare vascular event. Even in the presence of existing signs and symptoms, the diagnosis can be missed by experienced clinicians of all specialties. This is a report of a patient who presented with symptomatic bilateral dissection manifested as partial Horner's syndrome. The diagnosis was made after several clinical evaluations with the use of duplex ultrasound and angiography.

Case study

A 24-year-old white female in good general health developed a pulsatile headache localized to the right side of her face and temporal area that was associated with nausea and vomiting. She was seen by her primary physician and was noted to have right eye ptosis and miosis (Figure 1).

She was treated for herpes zoster and referred to a neurologist and an ophthalmologist after her condition failed to improve. She denied any visual symptoms, numbness or weakness of her extremities, or changes in coordination. She denied any history of antecedent trauma and she had only experienced occasional headaches in the past.

Physical examination revealed a healthy white female with obvious right ptosis and miosis (Figure 1). Her visual acuity was normal, as well as her reaction to light and cornea/retinal exam. Her neurologic exam revealed no focal deficits. Her blood pressure was 120/80 with no pressure gradient in both arms.

She was referred to a vascular surgeon and underwent duplex scanning which revealed severe stenosis of both internal carotid arteries (Figure 2). A carotid MRI revealed bilateral progressive tapering with long segment luminal narrowing of the internal carotid arteries (Figure 3), and tortuosity of the cervical portions of the arteries.

She was treated with warfarin and became asymptomatic. The warfarin was stopped after six months and a follow-up duplex ultrasound showed normal bilateral internal carotid arteries (Figure 4), which was confirmed by carotid MRI (Figure 5). She is to continue antiplatelet (aspirin) therapy indefinitely and refrain from oral contraceptives and smoking.

Discussion

Spontaneous ICAD recognition has increased with the use of angiography. One community study found that these dissections account for 2.5% of all first strokes! Another large review estimated that a given medical center may have only one

Figure 1. Photograph of patient showing right ptosis and miosis.

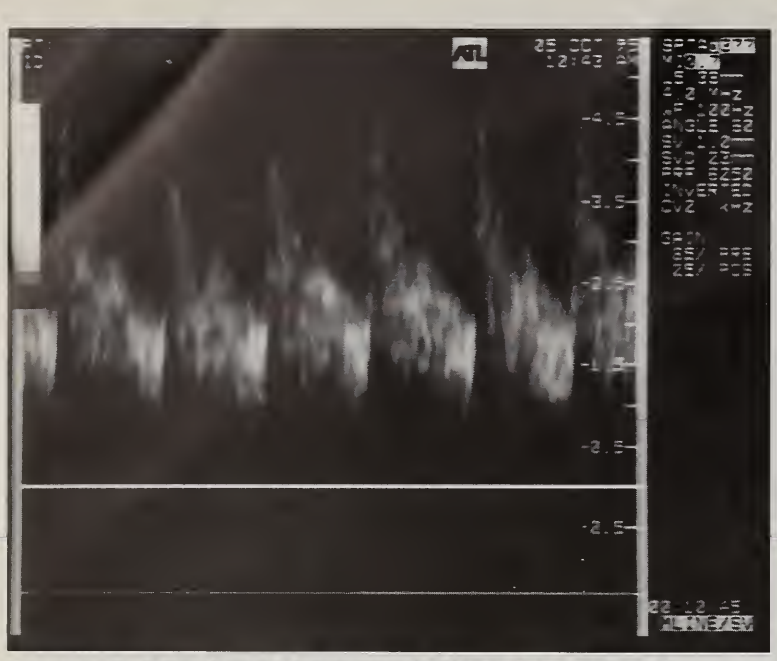

Figure 2. Duplex ultrasound of right internal carotid artery with a peak systolic frequency of > 5 kHz, which is suggestive of severe internal carotid artery stenosis.

Figure 3. Carotid MRI showing bilateral progressive tapering with long segment luminal narrowing of the internal carotid arteries.

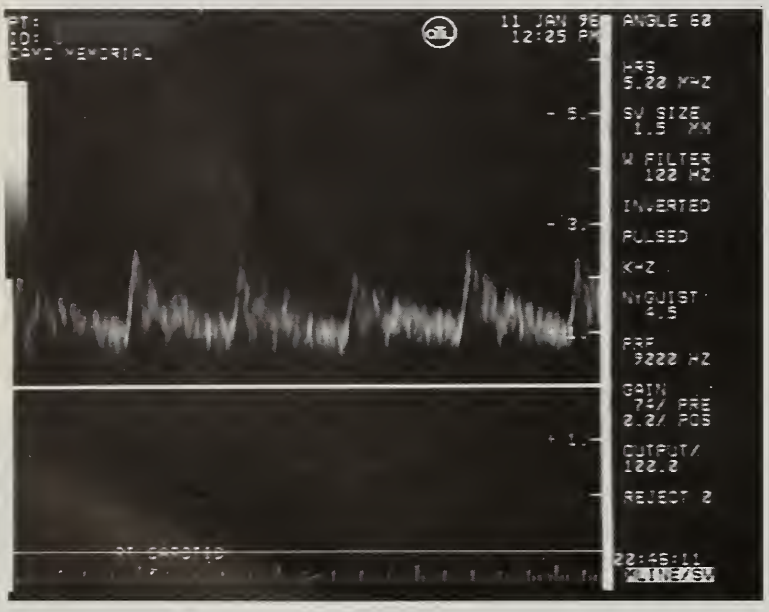

Figure 4. Duplex ultrasound showing a normal right internal carotid artery (a peak systolic frequency of < 3 kHz).

Figure 5. Carotid MRI showing a normal internal carotid artery.

case a year (1). The fact that this is a rare vascular entity explains the unclear delineation of the natural history, as well as the ideal therapeutic intervention.

The exact etiology of spontaneous ICAD is unknown. Fifteen percent of patients have associated fibromuscular dysplasia, and this increases to 50% with bilateral dissections. Cystic medial necrosis was thought to be a preceding factor early on, but this is less characterized. Risk factors for dissection, including hypertension, migraine headaches, smoking, and oral contraceptive use have been identified in a variable number of patients.

The average annual incidence rate has been defined as 2.6 per 100,000 patients of all ages, and the mean age at presentation was 44 years (2). The incidence of patients presenting with symptoms of focal cerebral ischemia has been reported to be 76% (3). These symptoms may be hemodynamic in origin, secondary to compression, but most authors believe they are due to distal embolization from thrombus.

An incomplete Horner's syndrome can occur due to involvement of the postganglionic sympathetic fibers traveling with the internal carotid artery. Facial sweating remains normal because the fibers traveling with the external carotid artery are spared. Referred pain to the ipsilateral head, face, or neck is the most common symptom. If this is associated with cranial or extracranial neurological deficits, the index of suspicion for dissection should be high.

Diagnosis has traditionally been confirmed with a conventional arteriogram. Recently, combined magnetic resonance imaging of the brain and magnetic resonance angiography have been suggested because these tests are non-invasive and can document evidence of cerebral hemorrhage or infarction. This can be helpful in planning therapeutic intervention.

Other non-invasive testing has been used, and duplex scanning is the most useful. The scan can identify a double lumen, intimal flap, or tapered occlusion. More commonly, the carotid bulb appears normal and the internal carotid artery has an absent flow signal or a high resistance flow. Duplex scanning is especially helpful with follow-up to identify residual stenosis or aneurysmal change after treatment.

Treatment for spontaneous dissection has drastically changed. Initially, operative treatment was recommended; however, a 30% occlusion rate, as well as a 15% perioperative stroke rate occurred. Patients treated with systemic anticoagulation had no additional neurologic symptoms and 90% had normal follow-up arteriograms.

Although no randomized trials have been done, the current treatment recommendation is systemic anticoagulation for at least three months (4). Surgical treatment is reserved for patients who have a recurrence of symptoms while on anticoagulation, residual significant stenosis after six months, or an aneurysm greater than 2 cm. Resection with an interposition graft is ideal, but ligation may be necessary if the process occurs up to the base of the skull and adequate stump pressure exists.

Conclusions

Spontaneous ICAD is an infrequent vascular entity with which all clinicians should be familiar. Early recognition with appropriate treatment can result in excellent clinical outcome.

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Guidelines for treating depression using non-selective serotonin reuptake inhibitors

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Abstract

While the Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants are safe and effective agents that are frequently prescribed for the treatment of depression, non-SSRI antidepressants also have potential benefits to offer the depressed patient. A review of the literature offers guidelines for choosing between these two therapeutic categories.

Introduction

The literature is replete with studies indicating that depression is a disorder seen frequently in the primary care setting. The physician's pharmacologic treatment of choice for depression is often a Selective Serotonin Reuptake Inhibitor (SSRI) (Table 1). Fluoxetine (Prozac), is reported to be the number one selling medication in the world (1).

The SSRI antidepressants are effective agents with a narrow range of side effects and an excellent safety profile. What then is the role of non-SSRI antidepressants (Table 2), which have now been on the market for more than 20 years prior to the introduction of the SSRIs? Most remain available as options for treating depression, but guidelines for choosing a non-SSRI vs. an SSRI antidepressant are scarce.

Table 1. Selective Serotonin Reuptake Inhibitors

1. fluoxetine (Prozac)
2. sertraline (Zoloft)
3. paroxetine (Paxil)
4. fluvoxamine (Luvox)
5. citalopram (Celexa)

Table 2. Tricyclic Antidepressants.

Tertiary Amines

1. imipramine (Tofranil)
2. amitriptylline (Elavil)
3. clomipramine (Anafranil)
4. trimipramine (Surmontil)
5. doxepin (Sinequan, Adapin)

Secondary Amines

6. desipramine (Norpramin, Pertofrane)
7. nortriptyline (Pamelor, Aventyl)
8. protriptyline (Vivactil)

Tetracyclic Antidepressant

1. maprotiline (Ludiomil)

Dibenzoxazepine

1. amoxapine (Asendin)

Triazolopyridine

1. trazodone (Desyrel)

Amino Ketone

1. bupropion (Wellbutrin)

Monoamine Oxidase Inhibitors

1. phenelzine (Nardil)
2. tranylcypromine (Parnate)
3. selegiline (Eldepryl, Deprenyl)

The choice of any medication is a complex process which includes the clinical presentation, the agents available, the medication's side effect profile and the physician's experience. In a 1994 article, Dr. S. Preskorn offered a mnemonic with the word STEPS to represent five variables that should be considered when choosing between a non-SSRI or SSRI antidepressant (2):

Safety
Tolerability
Efficacy
Payment (i.e. cost effectiveness)
Simplicity of use

This article will consider each of these variables.

Safety

It is generally agreed that as a class the SSRIs are safer than tricyclic antidepressants (TCAs), especially regarding death secondary to an overdose. The SSRIs neither prolong nor delay intracardiac conduction.

A 1993 report from Norway noted that the country's suicide rate had more than doubled between 1970 and 1988 (3). In 1970, there were 7.8 deaths per 100,000 and by 1988 there were 17.6 deaths per 100,000. During this 18-year span, TCAs were increasingly used to commit suicide. The two most commonly-prescribed TCAs in Norway, amitriptyline (Elavil) and doxepin (Sinequan) were also the antidepressants used most frequently to commit suicide. In comparison, an overdose of 3,000 mg. of fluoxetine during clinical trials resulted in two seizures in an individual with a seizure disorder history. No other sequelae were observed (1).

The use of TCAs, especially in the elderly, can pose other safety concerns. TCAs vary in their potential for causing side effects, which may include orthostatic hypotension resulting in falls and fractured bones, complications from anticholinergic side effects, e.g. bowel obstruction, aggravated glaucoma and the potential for arrhythmias. All are safety issues that favor use of the SSRIs over the TCAs in the geriatric population.

The SSRIs are not exempt when it comes to safety issues. With their well known tendency to inhibit the P450 cytochrome enzyme system, one must be aware of the possibility that with the use of multiple medications, toxic levels might be reached due to SSRI liver enzyme inhibition. In addition, elderly individuals are also more likely to be taking simultaneous medications for multiple conditions.

One might make a case that the non-SSRIs which do not significantly inhibit the P450 cytochrome system, such as heterocyclics, monoamine oxidase inhibitors and trazodone (Desyrel) might be considered "safer" from this standpoint.

Tolerability

Tolerability for side effects is determined by the various receptor sites that an antidepressant acts upon, as well as the variability within individuals for coping with side effects. Older antidepressant agents, especially the heterocyclics, act on histaminic, cholinergic and adrenergic receptor sites as well as dopamine and serotonin receptors and the side effects correspond to the sites affected. The SSRIs exhibit a narrower range of side effects, i.e., those related to the serotonergic system. These can certainly be as troubling to an individual patient as any of the side effects from non-SSRIs.

A study by Blackwell (4) addresses two issues pertaining to tolerability. A practitioner might be tempted to select an antidepressant with the least number of side effects in order to ensure patient compliance with taking the medications. The obvious assumption is that patients are more likely to take a medication if there are no side effects.

Blackwell followed outpatients with depression for a full year and discovered that while 2/3 of them dropped out of treatment, in 87% of patients receiving trazodone and in 17% of those receiving imipramine (Tofranil) was the cessation of treatment attributable to side effects. Common reasons for terminating treatment were recovery, the end of the initial prescription and a disbelief in the efficacy of the drug. In the same study, Blackwell discovered that providing both written and verbal education about potential side effects significantly reduced the dropout rate in people who experienced adverse effects.

Thus, we recommend that when physicians select a non-SSRI antidepressant (with its wider range of side effects) over an SSRI, they can improve the tolerability of that medication by counseling their patients about dealing with its most common side effects. If prescribing a tricyclic, a physician should include discussions about sedation, anticholinergic side effects, orthostatic hypotension and perhaps weight gain.

When prescribing monoamine oxidate inhibitors (MAOIs), we recommend that physicians discuss orthostatic hypotension and the need to monitor and avoid foods containing tyramine, as well as other specific contraindicated medications. Physicians should counsel a patient taking trazodone about the potential for side effects such as sedation and priapism, even though priapism is relatively rare. Bupropion (Wellbutrin) in the sustained release format may result in anorexia, dry mouth, tinnitus or tremors. In its slow release form, the potential for seizures has been reduced, but patients with bulimia, a history of seizures or head trauma, previous electroconvulsive treatments or those who have the potential for withdrawal are still at risk.

In counseling about the SSRI side effects, a physician should focus on the common side effects of sleep disturbance, sexual dysfunction, nausea or diarrhea. In fact, the side effects of SSRI suggest opportunities for use of a non-SSRI antidepressant. Trazodone, for example, has been used in low doses (50-100 mg.) to treat the insomnia caused by the SSRIs. Sexual dysfunction seen in patients taking the SSRI (i.e. delayed ejaculation and anorgasmia) has

been treated by adding bupropion to the SSRI (5), or by switching from the SSRI to a non-SSRI such as bupropion, with less potential for sexual dysfunction (6). There are several studies (7) which suggest that a non-SSRI, bupropion, is less likely than are the SSRIs to induce a manic episode in the bipolar patient who is in the depressed phase.

It is also important to take into consideration the fact that some of the early side effects of non-SSRI antidepressants abate with continued treatment. For example, orthostatic hypotension is seen primarily during the first two weeks of treatment and then subsequently resolves.

Efficacy

Numerous studies show that all of the antidepressants, SSRIs and non-SSRIs, are equally effective in the treatment of depression. What is noteworthy is that all of these studies regarding efficacy among the antidepressants were conducted in an outpatient setting.

There are two published inpatient service studies suggesting that non-SSRI may be more effective than an SSRI in the treatment of hospitalized patients suffering from depression. In 1986, the Danish University Antidepressant Group reported treating 114 inpatients with Hamilton Depression Scale (HDS) scores of $\geq$ 18 with either clomipramine (a TCA) or citalopram (an SSRI). All patients were treated with a single fixed dose, 150 mg. q.d. of clomipramine or 40 mg. q.d. of citalopram. A total of 102 patients completed the study and the results after five weeks showed a complete response in 60% of the clomipramine patients and in 30% of the patients receiving citalopram (8).

In 1990, the same group reported a six-week study using either clomipramine or paroxetine (Paxil) to treat 120 depressed inpatients. The Hamilton Depression Scale (HDS) was again used to define entry into the study as well as monitor progress. Therapeutic improvement was significant for clomipramine starting at week #2 (as compared with paroxetine). After six weeks, 50%-60% of the clomipramine patients and 20%-25% of the paroxetine group showed a complete response. There was a 30% partial response in both groups (9).

Another interesting question regarding efficacy is whether or not to switch to another SSRI or to a non-SSRI antidepressant if a patient does not respond to the initial SSRI. In a 1995 update to their book entitled *Principles and Practice of Psychopharmacotherapy,* Preskorn, Janicak, Davis and Ayd state:

There is no compelling evidence that non-responders to one SSRI due to a lack of efficacy will respond to a second trial with another SSRI. Therefore it may be more prudent to switch to a class of antidepressants with a different putative mechanism of action (10).

Price

It is probably intuitive that the non-SSRI antidepressants, particularly in their generic form, would cost less than the SSRIs. In 1995, a Pittsburgh physician discovered that a one-month supply of generic imipramine cost considerably less than a one-month supply of any SSRI antidepressant (11). He also found it interesting that a one-month supply of Tofranil prescribed by brand name was more expensive than any of the SSRIs.

Two studies have reported that when one factors in the cost of additional office visits due to side effects or treatment failures with a TCAs, there is little difference between the cost of the non-SSRI antidepressants and the SSRIs. In the United Kingdom, nefazodone (Serzone), a serotonin and norepinephrine reuptake inhibitor and a serotonin receptor antagonist, is about three times more expensive than imipramine. When additional office visits and treatment failures with imipramine were factored in the yearly cost per patient, the cost was equal to $373 for nefazodone and $497 for imipramine (12).

In a study published in *JAMA,* investigators compared the clinical, functional and economic outcomes for 536 patients treated with either fluoxetine, imipramine or desipramine by primary care physicians in the Seattle area. The study showed that patients taking fluoxetine reported fewer adverse effects; were more likely to continue with their originally prescribed medication; and were more likely to reach adequate doses than were patients who started treatment with either tricyclic drug. After three months, there were no major differences in outcomes. Total costs over six months were about equal for the three groups, with the higher cost of the fluoxetine group being balanced by lower number of outpatient visits and inpatient costs.

The investigators concluded that clinical outcomes, quality-of-life outcomes and overall treatment costs provide no clear guidance on initial selection of fluoxetine or tricyclic drugs. Thus, patients' and physicians' preferences are an appropriate basis for treatment selection (13).

Simplicity of use

Obviously, antidepressants which can be taken in a single dose offer an advantage over multiple dosing. However, a b.i.d. dosing regimen does not seem to be much better in regards to compliance

Antidepressant medications which need to be titrated upward in order to reach a therapeutic level rank lower on the simplicity scale. Patient concerns and the need to monitor for interactions between the MAOI and tyramine-containing foods compromise the ease with which these medications can be taken.

Summary

While there is no single factor that would prompt a physician to prescribe a non-SSRI over an SSRI (or an SSRI over a non-SSRI), comparing antidepressant agents regarding safety, tolerability of side effects, efficacy, cost and ease of use, and discussing these issues with the patient, facilitates a rational choice.

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At Mid-Winter

Topics for First Session to include urology, viral hepatitis A-G, x-knife, abnormal pap smears

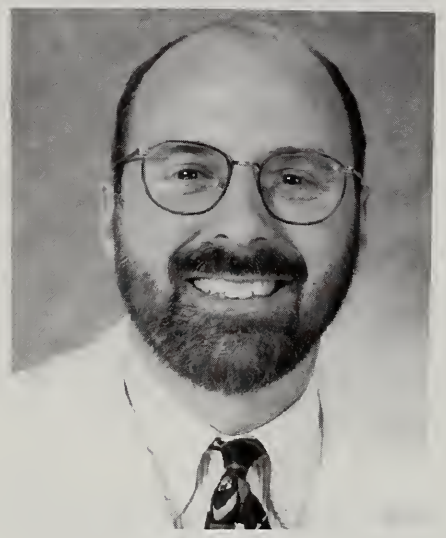
The First Scientific Session at this year's WVSMA Mid-Winter Clinical Conference at the Embassy Suites in Charleston will feature four lectures pertaining to the fields of urology, infectious diseases, neurosurgery and gynecology. This session will be moderated by **Daniel S. Foster, M.D.**, chairman of the Mid-Winter Clinical Conference Committee, and is set for Friday, January 22 at 1 p.m.

Charleston urologist **James P. Tierney, M.D.**, will begin this session with a discussion of *"What's New in Urology."* After Dr. Tierney's lecture, **Fredric G. Regenstein, M.D.**, chief of clinical hepatology and a clinical professor of medicine and surgery at the Tulane University School of Medicine, will present an *"Overview of Viral Hepatitis A-G."*

After a break, this session will reconvene with a lecture entitled *"X-Knife: A Neurosurgery Update"* by **Eben Alexander III, M.D.**, a neurosurgeon at Brigham and Women's Hospital and an associate professor in surgery at Harvard Medical School in Boston. The final presentation will be given by Charleston obstetrician/gynecologist **Paul H. Fulcher, M.D.**, who will discuss *"Evaluating Abnormal Pap Smears."* The four speakers will then join together for a question

Biographical information about the speakers begins in the next column. An outline of events, a registration form and other information about this year's meeting is published in this issue beginning on page 28.

If you need further details, phone the WVSMA at (304) 925-0342. To contact the Embassy Suites for room reservations, dial 1-800 Embassy or 347-8700.



Regenstein

Fulcher

Speakers highlighted

Dr. Tierney received an R.N. degree from Kings Daughters School of Nursing in Ashland, Ky., in 1973 and obtained a C.R.N.A. degree from the Charleston Area Medical Center School of Anesthesia in 1975 in Charleston.

The following year, he received a B.A. degree from Marshall University and then attended the West Virginia School of Osteopathic Medicine, where he obtained his D.O. degree in 1980. He completed his internship at Metropolitan General Hospital in St. Petersburg, Fla., and did a general surgery residency at the Charleston Area Medical Center and a urology and renal transplantation residency at the University of Pittsburgh.

Dr. Tierney currently practices urology in Charleston and he specializes in laparoscopic lymphadenectomy, cryosurgery, and contigen implants. In addition to being a member of the WVSMA and Kanawha County Medical Society, Dr. Tierney is a member of the American Urological Association and the Mid-Atlantic Section of the AUA, the West Virginia Osteopathic Association, Kanawha County Urological Association, and the Society of Urological Cryosurgeons.

Dr. Regenstein received his M.D. from the Washington University School of Medicine in 1978 and completed an internship and residency in medicine at Barnes Hospital in St. Louis. After his residency, Dr. Regenstein became a fellow in gastroenterology at Washington University and joined the faculty as an instructor in medicine.

Dr. Regenstein taught at Washington University for five years and then accepted a position at Tulane University School of Medicine as a clinical assistant professor of medicine in 1989. Since 1997, Dr. Regenstein has served as chief of clinical hepatology and as a clinical professor of medicine and surgery at Tulane.

A fellow of the American College of Gastroenterology, Dr. Regenstein is also a member of the International Liver Transplant Society and several national medical organizations. His current research activities include epidemiology and therapy of viral hepatitis types B and C, and clinical liver transplantation.

Dr. Alexander was born in Winston-Salem, N.C., and received his M.D. degree from Duke University School of Medicine, where he also completed an internship in general surgery and a residency in neurological surgery.

Following his residency at Duke, Dr. Alexander became a research fellow in neurosurgery at Massachusetts General Hospital and Harvard Medical School in Boston. In 1985, Dr. Alexander returned to Duke University Medical Center for further postdoctoral training in neuorological surgery. Two years later, he became the senior registrar and cerebrovascular fellow at Newcastle General Hospital in Newcastle-Upon-Tyne, England, and also served as a research fellow in neurosurgery at Brigham and Women's Hospital and Harvard Medical School.

Dr. Alexander is currently a neurosurgeon at Brigham and Women's Hospital and an associate professor in surgery at Harvard Medical School in Boston. He is a world renown lecturer and author, who currently serves on the editorial boards for *Neurosurgery*, the *Journal of Image Guided Surgery*, the *Journal of Stereotactic and Functional Neurosurgery*.

Dr. Fulcher obtained his M.D. degree from the West Virginia University School of Medicine in 1976. He interned and completed his residency in obstetrics/gynecology at the Charleston Area Medical Center.

Since 1980, Dr. Fulcher has been in private practice in obstetrics and gynecology. He also currently serves as clinical director of women and children's services at CAMC and is a clinical professor of obstetrics and gynecology at WVU.

A diplomat of the American Board of Obstetrics and Gynecology and the American Board of Medical Examiners, Dr. Fulcher is certified in advanced operative laparoscopy and advanced operative hysteroscopy by the Accreditation Council for Gynecologic Endoscopy. A fellow of the American College of Obstetrics and Gynecology, Dr. Fulcher served as chief of staff at CAMC in 1997.

"Affects of Abuse on Families, Particulary Children" subject for Lunch & Learn at Mid-Winter Conference

The popular Lunch & Learn event at this year's Mid-Winter Clinical Conference will feature three speakers who will discuss the *"Affects of Abuse on Families, Particulary Children."* This special luncheon is set for Saturday, January 23 at noon.

Cindy W. Christian, M.D., an assistant professor of pediatrics at the University of Pennsylvania and the Children's Hospital of Philadelphia, will be the keynote speaker for this event. Other speakers for this event will be **Linda L. Cooper, R.N. - C.S., M.S.N.**, director of the Family Resource Center at Women and Children's Hospital in Charleston; and **Regan Whitmyer, Esq.**, 1st assistant prosecuting attorney for Kanawha County.

Dr. Christian received her M.D. degree from Albany Medical College in 1985. She completed an internship and residency in pediatrics, as well as a fellowship in child abuse and neglect at the Children's Hospital of Philadelphia.

Christian

Cooper

Whitmyer

After her fellowship, Dr. Christian joined the staff at Children's Hospital, where she is now an assistant physician and an assistant professor of pediatrics. In addition, she currently serves as a consulting pediatrician for the Supportive Adult Child Network in Philadelphia and is very active in a number of state agencies dealing with child abuse issues.

A fellow of the American Academy of Pediatrics, Dr. Christian is the co-organizer of the national Child Abuse Physician Leadership Conference and has written extensively on the subject of child abuse and neglect.

Dr. Christian will also be the keynote speaker for this year's Physician/Public Session on Friday, January 22 at 7 p.m. during the Mid-Winter Clinical Conference at Embassy Suites. This session will be entitled *"Violence in the Home Becomes Violence in the Streets."*

Ms. Cooper has a B.S. degree in nursing from the University of Michigan and a M.S. degree from West Virginia University. She is certified by the American Nursing Association as a clinical specialist in adult psychiatric mental health nursing and as a licensed professonal counselor.

During her career, Ms. Cooper has held a variety of clinical and and counseling nursing positions, and she currently is director of the Family Resource Center at Women and Children's Hospital in Charleston, where she is also a psychiatric mental health clinical nurse specialist. She has presented a number of community and professional workshops on subjects such as grief and loss, stepfamilies, children and divorce, women & self-esteem, mother-daughter relationships, couples relationships, and parenting issues.

Ms. Cooper is a member of several professional organizations including the American Nurses Association, the International Transactional Analysis Association, and the American Association of Marriage and Family Therapists.

Ms. Whitmyer is a honors graduate of the Indiana University College of Arts and Sciences, and a 1981 graduate of the Ohio State University College of Law.

Since June 1981, Ms. Whitmyer has served continuously as an assistant prosecuting attorney. She has risen to the position of 1st assistant prosecuting attorney with the responsibility of assisting and supervising other attorneys with their trial work. Reagan is also an administrative officer, responsible for budget development and long range planning. As an assistant, she developed and implemented no-drop policies for the prosecution of domestic violence cases.

Ms. Whitmyer has received extensive training in the field of domestic violence and is certified as a trainer through the WV Coalition Against Domestic Violence. She teaches frequently at the State Police Academy and police, service and community organizations.

Fourth Session to feature two lectures prior to *"Stump the Audience"* segment

Kemeny

Stephens

This year's Fourth Scientific Session *"Potpourri of Topics"* at the WVSMA's Mid-Winter Clinical Conference will begin at 9 a.m. Sunday, January 23 with a lecture entitled *"Image Guided Breast Biopsies"* by **Margaret Kemeny, M.D.**, chief of the Division of Surgical Oncology at Stony Brook University Medical Center.

This presentation will be followed by a lecture on *"The Practical Use of Guidelines in Improving the Care of Patients with Low Back Pain in a Large Hospital System,"* by **Mark K. Stephens, M.D.**, principal clinical coordinator for the West Virginia Medical Institute, and **Marsha Lee Bailey, M.D., M.P.H.**, medical director of Corporate Health Services in Charleston.

After a break, this session will reconvene with the popular *"Stump the Audience"* segment in which three physicians will present challenging cases studies to see if the participants are able to guess diagnoses. This segment was described in detail in last month's *Journal.*

Dr. Kemeny received her M.D. degree from Columbia University College of Physicians and Surgeons in 1972. She did her internship at Presbyterian Hospital in NY and a residencies at the University of Colorado Medical Center.

From 1975-77, Dr. Kemeny completed fellowships in tumor oncology and in thoracic surgery at Memorial Sloan-Kettering Cancer Center. She then did her senior year surgical residency and her chief residency at Downstate Medical Center, and worked from 1979-81 as a clinical associate in the surgical branch of the National Cancer Institute in Bethesda, Md.

Dr. Kemeny is currently chief of the Division of Surgical Oncology at SUNY Stony Brook. A diplomate of the American Board of Surgery and a fellow of the American Board of Surgery, Dr. Kemeny is a past president of the Association of Women Surgeons and a member of many professionals organizations.

Dr. Kemeny has lectured throughout the world and she is the co-author of two books and over 100 articles, abstracts and book chapters. Since 1997, Dr. Kemeny has been an editor for the *American Journal of Surgery.*

Dr. Stephens obtained his M.D. degree from the Marshall University School of Medicine in 1983. During his early career, Dr. Stephens

was a primary care physician in Charleston and he was medical director of the Drug and Alcohol Rehabilitation Unit at CAMC. He also held physician reviewer positions for the WV Department of Health and Human Resources, MedSelect and Mountain State Blue Cross & Blue Shield, Inc.

In 1994, Dr. Stephens received an M.S. degree in health administration from the College of Graduate Studies in Institute. Since 1995, Dr. Stephens has been a member of the Medical Advisory Committee for Carelink and medical director of Healthplus Professionals. He also is a physician reviewer for Medicare and Medicaid, a physician reviewer for the Dept. of Veterans Affairs and he serves as principal clinical coordinator for the West Virginia Medical Institute.

An associate professor in the Dept. of Internal Medicine at WVU, Charleston Division, Dr. Stephens is board certified in internal medicine, addictionology and geriatrics.

Dr. Bailey received her M.D. degree from Marshall University in 1984. She interned at the Indiana University Medical Center and then became an occupational medicine physician and clinical director for Methodist Health Care, Inc. in Indianapolis and then for Barnes/ Sutter Healthcare, Inc. in St. Louis.

From 1989-1992, Dr. Bailey was an occupational medicine physician and corporate medical review officer for HealthLine Corporate Health Services, Inc. in St. Louis and she obtained a M.P.H. degree from the St. Louis University School of Public Health. For the next six years, she held management posts in Missouri and Ohio and completed a residency at the University of Cincinnati in the Dept. of Environmental Health.

Since August 1998, Dr. Bailey has held her current post as medical director for Corporate Health Services in Charleston.

Medical Assurance "keeping the promise" in West Virginia

Medical Assurance, the WVSMA's endorsed professional liability carrier, maintains a strong defense commitment for all its insureds. To date in WV, Medical Assurance has spent over $10 million in legal fees on more than 1,000 claims.

Of that amount, more than $6 million has been spent on the 800 claims still open; more will be spent prior to trial. Medical Assurance receives an average of 45 new claims per month, which means it's more important than ever to have the defense comitment of Medical Assurance on your side.

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Palliative care topic of July conference at Canaan Valley

The West Virginia Network of Ethics Committees in conjunction with The West Virginia Initiative to Improve End-of-Life Care will present *"Developing Competencies in Palliative Care"* from July 28-31 at Canaan Valley Resort and Conference Center.

Drawing on the EPEC (Education for Physicians on End-of-Life Care) program of the AMA, the National Hospice Organization's curricula for physicians and nurses, and the Care Beyond Cure educational program, this conference will provide physicians, nurses, social workers and clergy with the knowledge they need to develop or improve palliative care delivery systems in their institutions or communities.

Faculty will include Hank Dunn, M.Div., chaplain of Hospice of Northern Virginia and author of *"Hard Choices for Loving People,"* as well as Charlene Farrell, R.N., M.B.A.; Jacqueline J. Glover, Ph.D., James Keresztury, M.S.W., M.B.A.; Alvin H. Moss, M.D.; Sue Warren, M.D.; and Chris Zinn, R.N.

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Mid-Winter Clinical Conference *Highlights*

Thursday, January 21

1 p.m. -3 p.m.	Medical Assurance Loss Prevention Seminar
6:30 p.m. - 8 p.m.	**Legislative Reception**
8 p.m.	WVSMA Executive Committee Business Meeting

Friday, January 22

7 a.m.	WVSMA Committee on Medical Education
8 a.m. - 1 p.m.	WVMI Scientific Meeting
8:30 a.m. - 11 a.m.	*"Looking Ahead in CME: Plotting a Course for the Future"*
11 a.m. - 5 p.m.	WVSMA Registration
Noon	Publication Meeting
Noon - 2 p.m.	Local Health Officer's Luncheon, Hosted by the Bureau of Public Health
1 p.m. - 4:30 p.m.	Exhibit Visitation
1 p.m. -5 p.m.	**FIRST SCIENTIFIC SESSION** *"What's New in Urology"* James P. Tierney, MD *"Overview of Viral Hepatitis A-G"* Fredric G. Regenstein, MD *"X-Knife: A Neurosurgery Update"* Eben Alexander, III, MD *"Evalutating Abnormal Pap Smear"* Paul H. Fulcher, MD
3:30 p.m.	WVSMA Scientific & Education Sessions Committee Meeting
4:30 p.m. - 5:30 p.m.	Marshall University Alumni Board of Directors Meeting
5:30 p.m. - 7 p.m.	Reception, co-hosted by West Virginia University and Marshall University Schools of Medicine
7 p.m.	**PHYSICIAN SESSION/PUBLIC SESSION** ***"Violence in the Home Becomes Violence in the Streets"*** Cindy W. Christian, MD, assistant professor of pediatrics at the Children's Hospital of Philadelphia and University of Pennsylvania School of Medicine, Sgt. Tom Westfall, Marshall County Sheriff's Department and Jerome D. Massenburg, MD, Charleston Psychiatric Group

Saturday, January 23

7:30 a.m. - 8:30 a.m.	WVSMA Surgery Section Breakfast Meeting
8:30 a.m. - 4:30 p.m.	Exhibit Visitation/Registration
9 a.m.	WESPAC Board Meeting
9 a.m. - Noon	**SECOND SCIENTIFIC SESSION, "Controversies in Medicine"** ***"Antibiotic Treatment of Acute Pediatric Otitis Media"*** *"Controversies in Management of Acute Otitis Media"* Robert E. Polland, MD *"Toward Judicious Use of Antibiotics in Management of Otitis Media"* Kenneth M. Grundfast, MD, FACS, FAAP **"Alternative Medicine"** *"It Doesn't Have to be Either Or"* Tara Sharma, MD
11 a.m. -2 p.m.	WV Urological Society Meeting
Noon - 4 p.m.	WV Psychiatric Association
Noon - 1:30 p.m.	**Lunch & Learn** - ***"Affects of Abuse on Families, Particularly Children"*** Daniel S. Foster, MD, Moderator, Cindy W. Christian, MD, Linda Cooper, RN, MSN, Regan Whitmeyer, Esq.
Noon - 2 p.m.	WV State Society of Anesthesiologists
1:30 p.m. - 5 p.m.	**THIRD SCIENTIFIC SESSION , "End-of-Life Care"** *"Palliative Care: A Moral Mandate for All Physicians"* Alvin H. Moss, MD *"When is a Patient Dying: What Does the Medical Literature Say?"* Sue Warren, MD, FACP *"Patient-Centered Pain Management at the End-of-Life"* Timothy Deer, MD, DABPM, FAADEP *"The Ethics of Eating, Feeding, and Sedating at the End-of-Life"* Jacqueline J. Glover, PhD **Panel Presentation and Panel Discussion** - *"Dilaudid Did Not Touch Her Pain"*
7 p.m. - Midnight	Entertainment - Comedian/Attorney, Bob Noone, followed by Dr. Rano Bofill Hosted by Acordia of WV and Medical Assurance of WV

Sunday, January 24

7 a.m.	WVSMA Council Breakfast Meeting
8:30 a.m. - Noon	Exhibit Visitation/Registration
9 a.m. - Noon	**FOURTH SCIENTIFIC SESSION, "Potpourri of Topics"** *"Image Guided Breast Biospies"* Margaret Kemeny, MD *"The Practical Use of Guidelines in Improving the Care of Patients With Low Back Pain in a Large Hospital System"* Mark Stephens, MD and Marsha Bailey, MD *"Stump the Audience"* Robert J. Marshall,MD, Warren Point, MD, Moderators and distinguished guests, James E. Brick, MD, James Gregory Rosencrance, MD, and Kevin W. Yingling, MD

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Mid-Winter Clinical Conference

WV State Medical Association

Embassy Suites, Charleston, WV

January 21-24, 1999

Fax your Registration *NOW!*

Fax your registration form to (304) 925-0345 or call (800) 257-4747

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• Cancellation Policy: There will be a $50 administrative fee for cancellations after December 15, 1998

Registration Fees —

☐ WVSMA Member $125 ☐ Non-Member $175

Lunch & Learn — Saturday, Jan. 23, 1999

"Affects of Abuse on Families, Particularly Children," Cindy W. Christian, MD, Linda Cooper, RN, MSN, and Regan Whitmeyer, Esq.

☐ Physicians $50

☐ All others $35

To make room reservations, call the Embassy Suites at (304) 347-8700.

Join us for the

Physician/Public Session

"Violence in the Home becomes Violence in the Streets"

Friday, Jan. 22, 1999

7 p.m. - 9 p.m.

Salons A-B

Embassy Suites, Charleston, WV

Speakers include: Cindy W. Christian, M.D., assistant professor of pediatrics at the Children's Hospital of Philadelphia and the University of Pennsylvania School of Medicine; Sgt. Tom Westfall, Marshall County Sheriff's Department; and Jerome D. Massenburg, M.D., Charleston Psychiatric Group

WVSMA

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Don't Wait...Register NOW to

Lunch & Learn

Join us at the Embassy Suites during our 1999 Mid-Winter Clinical Conference for our popular Lunch & Learn program, Saturday, Jan. 23 at noon. This year's topic will be *"Affects of Abuse on Families, Particularly Children."*
Speakers include:

Cindy W. Christian, M.D.,
assistant professor of pediatrics at the Children's Hospital of Philadelphia.

Linda Cooper, R.N., M.S.N.,
director of the Family Resource Center at Women and Children's Hospital in Charleston.

Regan Whitmeyer,
assistant prosecuting attorney, Charleston

The cost for physicians is $50 and $35 for all others. 1.5 CME credits will be offered for the Lunch & Learn program.

Space is limited, so it is important to register NOW if you plan to attend this informative session.
To register, please call the WVSMA at (304) 925-0342 or (800) 257-4747 or visit the WVSMA Registration Desk during the Mid-Winter Clinical Conference.

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Acordia of WV and Medical Assurance of WV will host Bob Noone, a.k.a. "The Perry Mason of Parody," Saturday, Jan. 23 at 8:30 p.m. at the Embassy Suites. Hors-d'oeuvres will be served beginning at 7 p.m.

Following Bob's performance, Dr. Rano Bofill will delight the crowd with his famous laser karoke show and numerous dance contests!

Both Bob and Dr. Bofill said they are looking forward to entertaining physicians from around the state!

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CME & Special Events

Camcare Health Education & Research Institute

"Type II Diabetes: A Primary Care Approach"
(Seminar Jan. 27, 12:30 p.m. - 5 p.m.), Charleston Civic Center, Charleston

"Cardiology Conference at Snowshoe"
(With the American College of Cardiology) Feb. 2-4, Mountain Lodge Conference Center, Snowshoe

"Chemical Hazards in the Kanawha Valley"
Feb. 3, 12:30 p.m., Bipin Avashia, M.D., Montgomery General Hospital, Montgomery

"Management and Work-Up of Anemia"
Feb. 17, 6 p.m., Steven Jubelirer, M.D., Man Appalachian Regional Hospital, Man

"New Innovations in Cardiovascular Surgery"
Feb. 25, 5:45 p.m., John Chapman, M.D., Tamarack, Beckley

"Common Presentations of Acute Leukemia"
March 3, 12:30 p.m., Richard Williams, M.D., Montgomery General Hospital, Montgomery

"Gynecology in the Next Millennium"
March 9, 6 p.m., Paul Fulcher, M.D., Plateau Medical Center, Oak Hill

Huntington Community Medical Foundation

"Diabetic Foot Care"
Jan. 26, 6 p.m., Jeffrey Shook, D.P.M., Williamson Memorial Hospital, Williamson

"Introduction of Open Bore MRI"
Jan. 28, noon, Dennis Burton, M.D., Pleasant Valley Hospital, Point Pleasant

"An Overview of Interventional Radiology"
Feb. 10, 6:30 p.m., Paul Capito, M.D., The Brass Tree Restaurant, Williamson

"Ethical Dimensions of Health Care and What Physicians Need to Know About Advanced Directives"
Feb. 15, 6 p.m., Hoyt Burdick, M.D., and Paul English Smith, J.D., Three Rivers Medical Center, Louisa, Ky.

"New Diagnostic Testing in Acute Myocardial Infarction"
Feb. 25, noon, George Linsenmeyer, III, M.D., Pleasant Valley Hospital, Point Pleasant

Marshall University School of Medicine

"Diagnosis and Management of Late Life Depression"
Feb. 12, noon, Alan Seigal, M.D., MU Medical Center, Huntington

"Current Management of Lower Respiratory Tract Infections"
Feb. 25, 1 p.m., Sandra Elliott, M.D., Cabell Huntington Hospital, Huntington

"Research Days"
March 29-30

Robert C. Byrd HSC - Morgantown

"Conference on Rural Health Services"
March 17, Robert C. Byrd HSC of WVU, Morgantown

"Sixth Annual Stephen C. Rector Visiting Lectureship in Emergency Medicine"
April 22, Robert C. Byrd HSC of WVU, Morgantown

"The Edward H. Stullken, Jr. Lectureship: Trends in Managed Care"
April (Tenative), Robert C. Byrd HSC, Morgantown

"STD/AIDS in West Virginia '99"
May 6-8, Embassy Suites, Charleston

"Virginia and West Virginia Societies of Anesthesiology Annual Meeting"
May 28-30, The Greenbrier, White Sulphur Springs

"Advanced Life Support in Obstetrics"
July 23-25, Canaan Valley Resort, Davis

"Developing Competencies in Palliative Care"
July 28-31, Canaan Valley Resort, Davis

"25th Annual Hal Wanger Family Medicine Conference"
Sept. 30 - Oct. 2, Robert C. Byrd HSC of WVU, Morgantown

West Virginia State Medical Association

WVSMA's Mid-Winter Clinical Conference"
Jan. 21-24, Embassy Suites, Charleston

WVSMA's Annual Meeting
Aug. 25-28, The Greenbrier, White Sulphur Springs

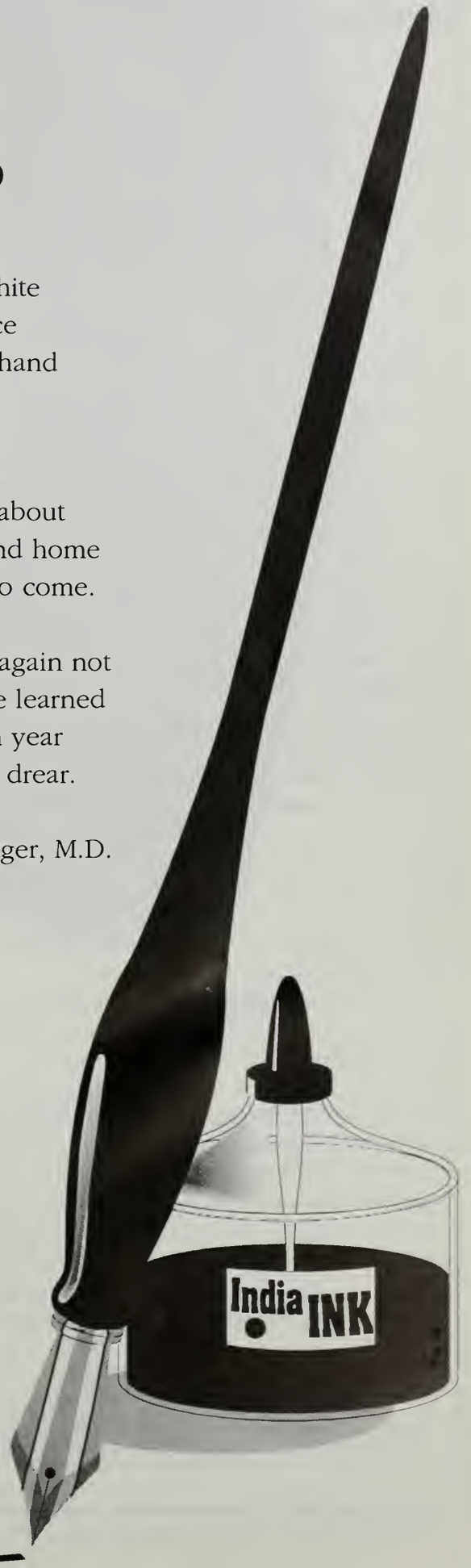
Winter's Grasp

Cold winter stands in raiment of pure white
With hoar-frost etched upon his rigid face
And stretches out his blue-tinged, frigid hand
To scatter snow upon the sleeping land.

Now everywhere the people scurry past
While clutching coats to pull them tight about
And gladly seek the warmth of hearth and home
While dreaming of warm summer days to come.

Thus winter's grasp nows finds us once again not
Quite prepared; yet we should well have learned
That winter comes around this way each year
And tortures us with drab days cold and drear.

E. Leon Linger, M.D.



Motorcycle helmets: A major key to injury prevention

Motor vehicle crashes are one of the leading causes of death and disability in the United States. Motorcycle crashes alone claim the lives of over 2,100 riders each year. In fact, **motorcyclists are 16 times more likely than automobile occupants to die in a traffic crash** and about four times as likely to be injured. While only 20% of car crashes result in injury or death, that figure leaps to an astounding 80% for motorcycle crashes.

Motorcycling enthusiasts enjoy a unique degree of freedom and "connectedness" with the outdoor environment that is impossible with any other vehicle. But, along with this enhanced riding experience comes a responsibility to **practice safe and conscientious riding habits in order to minimize the risks** that are indisputably a part of motorcycling.

A comprehensive motorcycle safety program works to prevent crashes, reduce resulting injuries, and provide rapid emergency medical response and treatment for victims when injuries do occur. **The use of a helmet when motorcycling is the single most effective way to reduce the possibility of severe injury or death** in motorcycle-related accidents.

A highway motorcycle crash is typically a violent event. More than **80 percent of all reported motorcycle crashes result in injury or death** to the motorcyclist. The construction of a motorcycle provides none of the protection to the rider that passengers of automobiles enjoy. Motorcycles are smaller and harder to see, less stable than four wheeled autos, and are unable to provide seatbelt protection. Ejection from the motorcycle is a common injury pathway.

The National Highway Traffic Safety Administration, in its report to Congress entitled *"The Benefit of Safety Belts and Motorcycle Helmets,"* confirmed that motorcycle helmets are 67% effective in preventing brain injuries. **Unhelmeted riders triple their chance of serious head and brain injury**. Studies have also found that hospitalization and related **medical expenses are twice as high for unhelmeted riders**.

In West Virginia, the helmet law has helped save many lives since it was first enacted in 1971. In spite of the abundance of hard data illustrating the benefits of helmet usage, there remain some groups of riders who lobby annually to have the law thrown out.

"During the West Virginia Legislature's consideration of the helmet issue two years ago, I became aware that the vast majority of my constituents favor helmet laws," Senator Michael Oliverio said. "I believe our vote to preserve this law has saved lives. I would like to see the law extended to include all terrain vehicles (ATVs) as well."

One bill being introduced in the current Legislative session would require riders of ATVs to wear helmets and eye protection and would prohibit the extremely dangerous practice of operators carrying passengers. Equally important, the proposed bill would limit youngsters to smaller vehicles with engines under 90cc.

With an estimated 80,000 all terrain vehicles in West Virginia, the extension of helmet and safety laws to include ATVs could have enormous benefit. Currently, West Virginia's death rate from ATV accidents is five times the national average, and second only to Alaska. Nineteen West Virginians died on ATVs in 1997 and eight of them were under 16 years old. Since the state began tracking death rates on ATV-related accidents in 1985, there have been 113 reported deaths.

The West Virginia Bureau for Public Health strongly supports the Legislature's efforts to address this serious problem which is increasingly threatening the safety of citizens in the Mountain State.

Penny Byrnside, R.N., B.A.
Injury Prevention Coordinator
Emergency Medical Services
Bureau for Public Health

Mark Ferrell
Communications Coordinator
Bureau for Public Health

* *All national statistics were acquired from the National Highway Traffic Administration. The ATV statistics were obtained from the Center for Rural Emergency Medicine at WVU.*

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1021 National Road, Wheeling, WV

Robert C. Byrd Health Sciences Center of West Virginia University News

Hermanova earns medal from British Geriatrics Society

Dr. Hana Hermanova, director of the WVU Center on Aging, proudly holds the Medal for the Relief of Suffering Amongst the Aged which she was presented by the British Geriatrics Society.

Dr. Hana Hermanova, director of the WVU Center on Aging, has been awarded the Medal for the Relief of Suffering Amongst the Aged by the British Geriatrics Society.

Dr. Hermanova is the fourth person to receive this medal, which was presented to her at the Society's annual dinner in London in recognition of her work with the World Health Organization. She has chaired several programs on aging for the WHO and is a member of the organization's Panel on the Health of the Elderly.

Brick to lead Dept. of Medicine

Dr. James E. Brick has been named chair of the Dept. of Medicine in the WVU School of Medicine. He has been acting chair since July 1997.

Dr. Brick, a rheumatologist, joined the School of Medicine faculty in 1981. He is widely known for his research in arthritis treatment and in telemedicine.

Lab offers cytogentic analysis

University Medical Laboratories (UML) services now include chromosome analysis for the diagnosis of genetic syndromes and many hematological disorders.

UML, located at WVU Hospitals, is certified by the College of American Pathologists for cytogenetic analysis on a variety of specimens, including amniocytes, chorionic villi, peripheral blood, bone marrow and solid tissues.

The cytogenetics laboratory includes state-of-the-art computer imaging and molecular/cytogenetic techniques to characterize numerical and structural abnormalities. The technique of fluorescence in situ hybridization (FISH) uses DNA probes to detect microdeletion syndromes and cancer rearrangements.

Other related tests offered by UML include maternal serum triple screen, AFP, acetylcholinesterase and fragile X molecular testing. A complete listing of tests is available from the UML office, or on the West Virginia Physician Page (www.wvmd.wvu.edu) on the internet.

The laboratory also offers referral to genetic counseling services for patients with abnormal test results and consultation regarding reference laboratories for diagnosis of genetic disorders through molecular testing.

Assistance from UML is available 24 hours a day, seven days a week at 1-888-865-3678.

Helsley named to med director post

Dr. James D. Helsley of Family Medicine has been named medical director of the Visiting Clinician Program.

This program links primary care physicians and dentists to the Robert C. Byrd Health Sciences Center by making them part of the academic center. Physicians and dentists visit the Health Sciences Center periodically as teachers, students, and if they wish, as researchers. Currently, 89 physicians from West Virginia participate in the program.

Dr. Helsley, a WVU School of Medicine graduate, joined the faculty in 1991.

Pediatrics Dept. earns reaccreditation

The WVU Dept. of Pediatrics has earned full reaccreditation from the pediatric residency review committee of the American Council of Graduate Medical Education. Representatives from the committee visited the department in September.

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Marshall University School of Medicine News

Technology learning center to aid students, rural health providers

Dr. Robert Walker (seated) and Kent Hayes, director of clinical and administrative computing, review materials available in the Lewis Technology Center of the Center for Rural Health. *(Photo by David Fattaleh)*

A technology learning center in the Robert C. Byrd Center for Rural Health will help rural providers as well as med students become familiar with the high-tech tools of the computer age.

"This will provide a teaching lab for a wide variety of information technology applications, ranging from office automation products such as Microsoft Word and Power Point to specialized Internet training on locating medical information needed by providers and patients," said Michael McCarthy, MU's assistant dean for information technology and medical informatics.

The Margaret L. Lewis Technology Learning Center has eight workstations for learners and a ninth for the instructor, as well as other teaching tools.

"One of the complaints we hear over and over from rural providers is that they can't afford the technical support needed to allow them to use the new computer hardware and software they know is out there," said Dr. Robert B. Walker, director of the Center for Rural Health and chair of the Dept. of Family and Community Health. "Now people in rural health will be able to come up here and have us teach them how to use these important tools."

McCarthy said the lab will provide a central training site for rural site coordinators in the Rural Health Education Partnerships program, for example.

Belshe to speak at Research Day

Vaccine researcher Robert Belshe, M.D., formerly professor of medicine at Marshall, will be the keynote speaker at the school's annual research conference March 29-30.

Dr. Belshe is director of the Center for Vaccine Development at St. Louis University, where he is professor of internal medicine and director of the division of infectious diseases and immunology. He was the lead author of *"The Efficacy of Live Attenuated, Cold-Adapted, Trivalent, Intranasal Influenza Virus Vaccine in Children,"* which appeared in the May 14, 1998, edition of *The New England Journal of Medicine.*

Dr. Belshe will speak at the opening session on *"Live Attenuated Influenza Vaccine: Using Viral Genetics to Defeat the Flu."* This session is from 6 p.m. to 9:30 p.m. on March 29 at the MU Medical Center. The next day, the session will take place from 8 a.m. to 3 p.m. at the Radisson Hotel, and Dr. Belshe will speak at noon on *"Vaccines for the 21st Century."*

The research conference, Marshall's 12th, will feature research presentations and clinical case presentations by students, residents and faculty in both the clinical and basic sciences. Registration information is available from the Office of Continuing Medical Education, 691-1770.

Marshall conducts COPD trial

Volunteers are needed to participate in a medical research study evaluating the safety and effectiveness of an investigational treatment for chronic obstructive pulmonary disease.

Interested individuals must be 40 years of age or older, be a current or ex-smoker and have a diagnosis of emphysema or chronic bronchitis.

Involvement in the study will require an initial exam and 11 treatment visits to the clinic. The total study will last up to six months. There will be no financial cost for patients accepted into the study. All examinations, laboratory tests and study drug treatment are free of charge. Qualified participants will be compensated for their time and efforts.

West Virginia Chapter — American College of Surgeons

Annual Spring Meeting

April 29 — May 1, 1999

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Guest speakers:

Lawrence Reed, III, M.D., F.A.C.S.,
Professor of Surgery, Division Chief, Trauma, Surgical Critical Care and Burns, Loyola University Medical Center

Olga Jonasson, M.D., F.A.C.S.,
Director Education and Surgical Service Department, American College of Surgeons

Speakers from the Southwestern Pennsylvania Chapter, the West Virginia Chapter and residents from WV training programs will complete the program. A golf tournament and reception will be Friday. There will be a $100 registration fee and 10.5 CME hours are available. For more information, contact Sharon Bartholomew at (304) 598-2802. For room reservations, contact The Greenbrier at (800) 624-6070.

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West Virginia School of Osteopathic Medicine News

Work progressing on new library facility

Construction work is expected to be completed this spring on the new facility which will house a high-tech library, new bookstore, a new Osteopathic Principles and Practice laboratory, and additional student study space.

This spring, work is scheduled to be completed on the $2 million renovation of an existing WVSOM structure to create a new high-tech library, bookstore, Osteopathic Principles and Practice laboratory, as well as additional student study space. A new breezeway is also being built to attach the free-standing facility to the main school building.

"We offer an outstanding medical program with wonderful facilities," said WVSOM President Olen E. Jones Jr., Ph.D. "We feel that this renovation is just another step in WVSOM's continuing evolution towards one of the most complete, state-of-the-art, aesthetically pleasing campuses in all of West Virginia," he added.

Kanawha, Roane County students visit WVSOM

The WVSOM is not only a training ground for future doctors, but also an effective learning center for high school students interested in careers in science and health.

Fourteen high school students visited the WVSOM campus recently to tour the school and learn about anatomy and osteopathic medicine. The students were participating in the Health Sciences and Technology Academy (HSTA) from Kanawha and Roane Counties.

Students were given an overview of osteopathic medicine by Bill Lemley, D.O., associate professor of osteopathic manipulative medicine, followed by a campus tour. The highlight of the tour was a visit to the Anatomy Lab where a gross anatomy presentation was conducted by second-year medical students Jason Vaughn and Rob Snuffer.

For more information about WVSOM and tour programs, phone 1-800-356-7836, ext. 207.

WVSOM celebrates National Osteopathic Medicine Week

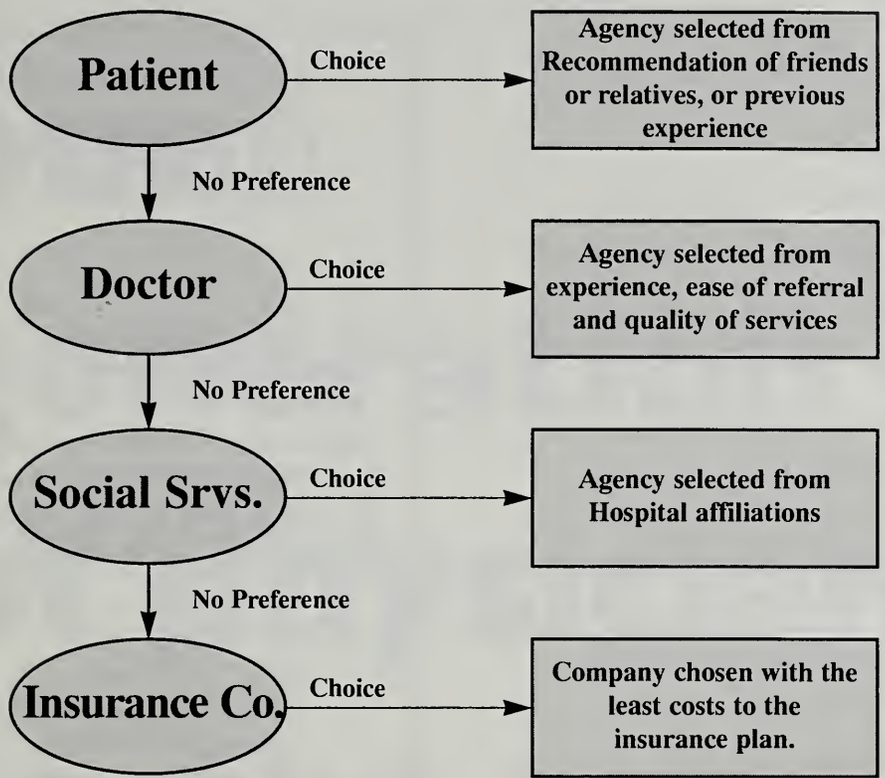
The WVSOM joined its 18 peer institutions across the nation in celebrating National Osteopathic Medicine (NOM) Week on Nov. 1-7.

This year, NOM week focused on how women can cope with the physical changes taking place during menopause by emphasizing preventive medical strategies and by following a holistic approach to health care.

WVSOM kicked off NOM week with the annual Women's Health Screening, offering free screenings for cervical, colon and breast cancer. Other events included a community get together at Mattie's Coffee Shop, the "D.O. a Good Deed" program at the Lewisburg Senior Center, several women-oriented programs at the school, including one entitled "Sexual Assault Protocol," and the "Medical Student for a Day" program.

"This is the second year in a row we've sponsored the 'Medical Student for a Day' program," said Carolyn Thompson, Ed.D., associate dean for student affairs. "Our students enjoy being mentors to the high school students and showing them around the school. A lot of the students are interested in careers in medicine and for many of them this is their first exposure to medical school," Dr. Thompson explained.

Healthcare — Who's Choice is it?



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New Members

We are pleased to welcome the following new members to the WVSMA as of January 11:

Physicians

Wladimer Zyzneswky, MD
Wheeling, WV

Elissa J. Hoffman, MD
Morgantown, WV

Michael D. Roberts, MD
Parkersburg, WV

Colin A. Rose, MD
Ronceverte, WV

Heather Rose, MD
Ronceverte, WV

Barbara M. Broerman, MD
Morgantown,WV

Jonathan Herland, MD
Morgantown, WV

Frank J. Keefer, MD
Wheeling, WV

Thomas E. Chvasta, MD
Wheeling, WV

Bruce F. Haupt, MD
Charleston, WV

Said Edward Said, MD
Martinsburg, WV

Linda Linger, DO
Wheeling, WV

Mathew G. Sokos, MD
Wheeling, WV

Samuel J. Bracken, Jr., MD
Wheeling, WV

Lawrence C. Kelly, DO
Wheeling, WV

Eduardo Esper, MD
Weirton, WV

Robert E. Jones, MD
Wheeling, WV

Sunila Mehrotra, MD
Wheeling, WV

Julian L. Espiritu, Jr., MD
Charleston, WV

Rosalind L. Go, MD
Charleston, WV

Dante R. Geronilla, MD
Charleston, WV

Utaiwan P. Suvannoparat, MD
Charleston, WV

James Malone, DO
Clarksburg, WV

Tara C. Sharma, MD
Huntington, WV

Daniel J. Wood, MD
Charleston, WV

Lionel J. Nair, MD
Charleston, WV

Keith A. Recht, MD
Martinsburg, WV

Arturo Lim, MD
Charleston, WV

Mely Lim, MD
Charleston, WV

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405 Ann Street
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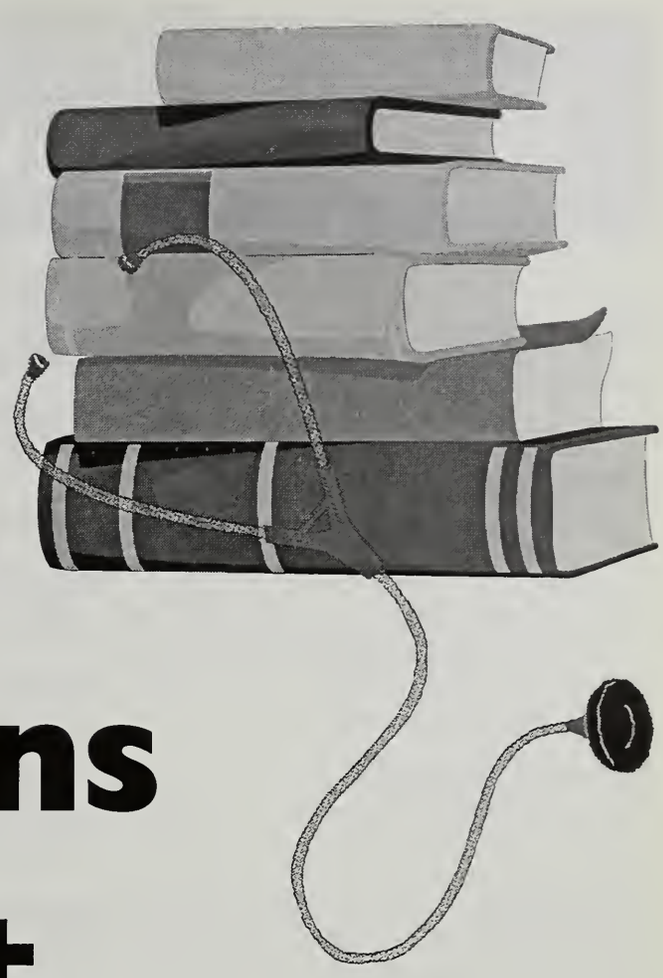
LEXINGTON
LEXINGTON, KY
890 Russell Cave Road
(606) 252-2661

From one generation of physicians to the next.



Make a difference in the **future** of medicine by supporting the West Virginia AMA Foundation.

Your *tax deductible* contribution may be designated to go to:

- **A medical school of your choice**
- **The Medical School Excellence Fund, which allows the medical school to use the money any way they see fit.**
- **Or, the Medical Student Assistance Fund, which is used specifically for student scholarships.**
- **Make checks payable to AMA Foundation, with a note on the memo line to specify which school and fund donation you select.**
- **Mail checks to Michelle Latos, 2 Augustwood, Wheeling, WV 26003. For information about AMA Foundation, call (304) 233-7480**

WESPAC News

We would like to thank the following individuals for their recent contributions to the 1999 WESPAC Fund:

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Weirton
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Ohio
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Cindy D. Hess

Ohio
Dawn B. Noble

You're invited to the

WVSMA-MSS Annual Meeting

January 23, 1999
Embassy Suites Hotel
Charleston, West Virginia

---

8 a.m. - 8:30 a.m.	**Registration** - Exhibit Hall/WVSMA Registration Desk, Salon D-E
8:30 a.m. - 9 a.m.	**Welcome** - WVSMA President David W. Avery, M.D. WVSMA Acting Executive Director, Nancie G. Albright WVSMA-MSS President Steve Greer
9 a.m. - Noon	**Special Section** **"Controversies in Medicine"** *"Controversies in Management of Acute Otitis Media"* Robert E. Polland, MD, Charleston *"Toward Judicious Use of Antibiotics in Management of Otitis Media"* Kenneth M. Grundfast, MD, FACS, FAAP, Washington, DC
10:15 a.m.	**Refreshment Break** Exhibit Center, Salon D-E
10:45 a.m.	***"Alternative Medicine"*** *"It Doesn't Have To Be Either Or"* Tara C. Sharma, MD, Huntington
11:30 - Noon	Questions & Answers Discussion
Noon - 1 p.m.	Luncheon - Provided by the WVSMA-MSS
1:15 p.m. - 3:15 p.m.	Business Meeting • Presidential Address • Component Society Reports • Election Nominations • Committee Reports

---

Name_____

Address_____

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Will you attend the luncheon?_____

Are you a WVSMA-MSS member?_____

Please fax to (304) 925-0345, attn: Donna Webb at WVSMA-MSS,
or mail to P.O. Box 4106, Charleston, WV 25364
If you have questions about the meeting, please call (800) 257-4747 or (304) 925-0342.

Obituaries

Winfield C. John, M.D.

Dr. Winfield C. John, 79, of Huntington died at his home surrounded by his family on November 12.

Dr. John was born December 20, 1918 in Uniontown, Pa., a son of the late Chad L. and Edna Arford John. He was a veteran of World War II, serving in the Army as a Captain in the Medical Corps.

A graduate of Duke University and the University of Pennsylvania Medical School, Dr. John completed his residencies in neuro-psychiatry, allergy and internal medicine. He began his private practice in January 1950 at the Rowley Clinic in Internal Medicine and at the VA Hospital Allergy Clinic. He retired in 1989.

Dr. John was a former chief of staff of the Huntington Hospital. He served as a board member for the Huntington Clinical Foundation and the Huntington Foundation. He was a member of the Marshall University Foundation, where he was awarded the Circle of Gold.

Dr. John had been a member of the WVSMA since 1952, serving on Council for many years. In addition, he was a member of the Norval Carter Society, the AMA, a former board member of the Southern Medical Association and the Cabell County Medical Society, a former board member of the Western West Virginia Chapter of the American Red Cross, a former board president of the American Cancer Society, and a member and former elder of the Spring Valley Presbyterian Church.

Dr. John was one of two doctors who were instrumental in establishing the Marshall University School of Medicine.

Survivors include his wife, Alice Patterson John; one son and daughter-in-law, Winfield C. John, III, D.M.D., and Linda John, Ashland, Ky; two daughters and a son-in-law, Bridget Walton, Richmond, Va., and Carolyn and Ron Grimes, Huntington, W.Va.; five grandchildren, Angela Grimes Watts, Christopher Grimes, Adrienne John, W.C. John, IV and Andrew Walton; two brothers, Chad A. John, Pa., Carl L. John, Az.; and one sister, Helene Emmett, NY.

Donations may be made to the American Cancer Society of Cabell County, or the Memorial Fund of the Spring Valley Presbyterian Church.

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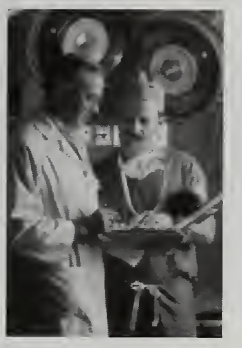

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For Advertising Rates and Information, Phone Christina Dixon at (304) 925-0342.

Marshall University School of Medicine

ASSOCIATE/ASSISTANT PROFESSOR — The Department of Pathology is seeking one or more individuals for faculty positions available July 1, 1999. Candidates must hold an M.D. degree and be board certified or board eligible. Candidates trained in Anatomical and Clinical Pathology with specific interest in dermatopathology will be given special consideration. Clinical duties coupled with teaching responsibilities will be required.

Please send CV, letter of interest, and three letters of reference to David Porter, M.D., Chair, Department of Pathology, 1542 Spring Valley Drive, Huntington, WV 25704. Marshall University is an AA/EOE. Minorities and women are encouraged to apply.

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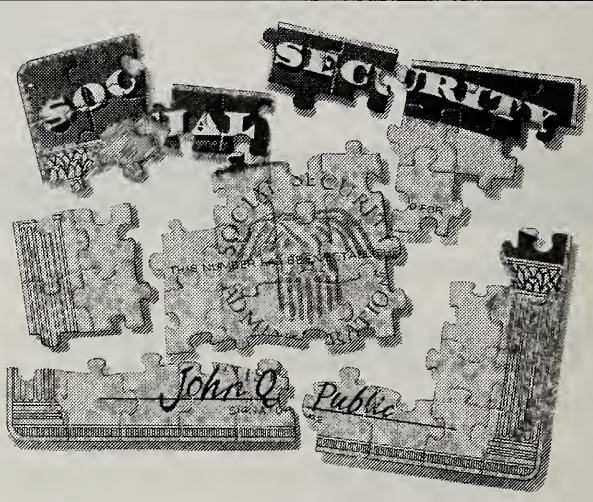

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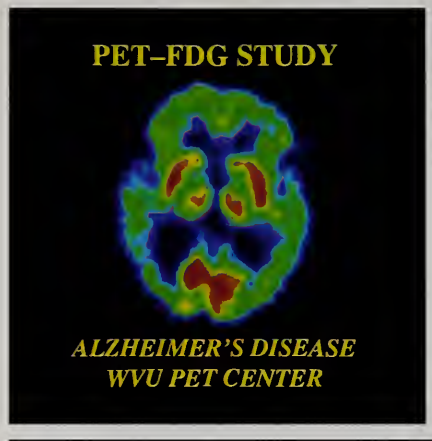

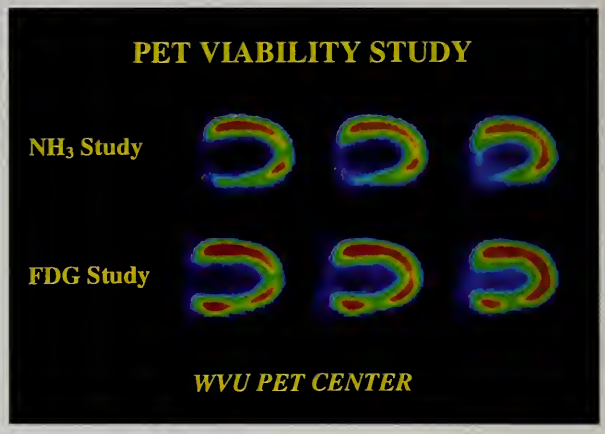

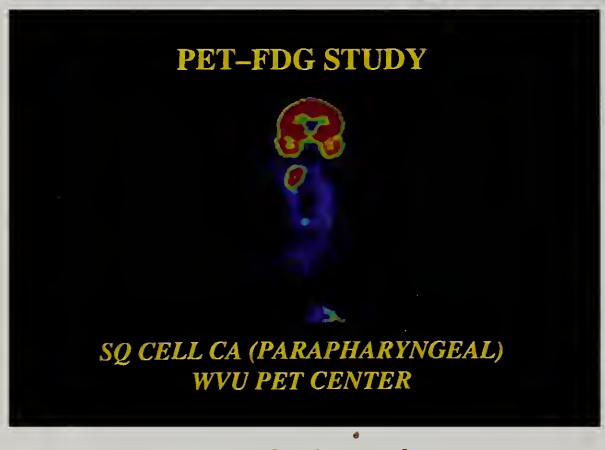

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PET REIMBURSEMENT

HCFA has announced Medicare Reimbursement for diagnosis and staging of Lung Cancer and Lung Nodules starting January 1998. Blue Cross Blue Shield and many other third party insurance carriers have routinely reimbursed for these and many other PET studies that are deemed clinically indicated.

West Virginia Medical
JOURNAL
Volume 95 No. 2 West Virginia State Medical Association March/April 1999

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The Camcare Health Education and Research Institute's CME program is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. For more information on these and future programs provided by the Institute, please call 304-388-9960 or fax (304) 388-9966 or send e-mail to tkuhn@camcare.com.

Seminars

OB/GYN Update: A Pre-conference For the Family Physician
Thursday, April 22, 1999
5 to 9 p.m.
Charleston House Holiday Inn
Charleston, WV
E. Reed Heywood, MD
Program Chairman

26th Annual Newborn Day: Hematology Disorders of the Newborn
Friday, April 23, 1999
7:30 a.m.
Tamarack, Beckley, WV
Stefan Maxwell, MD
Program Chairman

Issues in Medical Ethics
Wednesday, June 9, 1999
8 a.m. to 5 p.m.
Tamarack, Beckley, WV
Robert T. Hall, PhD
Program Chairman

On-Site Continuing Education Outreach Program

Common Foot Problems
April 5, 1999
12:30 p.m.
Montgomery General Hospital
Montgomery, WV
Scott Glassburn, DPM

Treatment of Depression
April 20, 1999
5:45 p.m.
Tamarack, Beckley, WV
Mark Casdorph, DO

Black Lung Evaluation
April 21, 1999
6 p.m.
Man ARH
Man, WV
James Walker, MD

Geriatric Trauma
April 26, 1999
5:45 p.m.
Cafe Acropolis
Summersville, WV
Frank C. Lucente, MD

Medical Ethics
May 5, 1999
Noon
Montgomery General Hospital.
Montgomery, WV
Josiah K. Lilly, MD

Emergency Room Assessment of Motor Vehicle Accidents
May 14, 1999, 12:00 p.m.
Logan General Hospital
Logan, WV
Leonard Allen, MD

Pediatric Emergencies
May 18, 1999
6 p.m.
Roane General Hospital
Spencer, WV
Gordon Green, MD

COBRA Issues
May 19, 1999
6 p.m.
Man ARH
Man, WV
Mark K. Stephens, MD

Geriatric Trauma
June 16, 1999
6 p.m.
Man ARH
Man, WV
Frank C. Lucente, MD

Acute Renal Failure
July 21, 1999
6 p.m.
Man ARH
Man, WV
Robert V. Lamb, III, MD

Guest Lectures

Tumor Conference
Prostrate Cancer
April 12, 1999
Noon
Robert C. Byrd Health Sciences Center of WVU/Charleston Division
Room 2000
Daniel Petrylak, MD
Colombia Presbyterian Medical Center
New York, N.Y.

Cardiology Conference
Coronary Artery Risk Detection in Appalachian Communities
April 21, 1999
8 a.m.
Robert C. Byrd Health Sciences Center of WVU/Charleston Division
Room 2000
William Neal, MD
Robert C. Byrd Health Sciences Center of WVU
Morgantown, WV

Camcare Health Education and Research Institute

The Search Is On for Outstanding West Virginia Physicians

Why we honor our physicians

It is once again that time of year. Time to honor and recognize a fellow physician or outstanding individual who has made an invaluable contribution to medicine or health care in West Virginia. When nominating a fellow physician or a member or your community, please remember that this is an opportunity to recognize someone who has done excellent service to his or her community and has been an asset to the state of West Virginia. While honoring others we are all encouraged to act similarly.

The Awards

We are now accepting nominations for the Wyeth-Ayerst Physician Award for Community Service, the Rural Health Physician of the Year and the West Virginia Presidential Citation. The following awards will be presented at the 132nd Annual Meeting at The Greenbrier, August 25-28.

- The **Wyeth-Ayerst Physician Award for Community Service** recognizes a physician who has uniquely contributed to the community.
- The **Rural Health Physician of the Year** recognizes a physician who offers exceptional medical care to patients in smaller, rural areas.
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A tall bearded iris heralds the return of spring to Charleston.

Photo courtesy of Nancy L. Hill, managing editor, West Virginia Medical Journal.

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Manuscript Guidelines

All articles for the *West Virginia Medical Journal* must be submitted on an IBM compatible disc. Wordperfect 5x, Wordperfect 6.0/6.1, Microsoft Word for DOS, and other languages are acceptable. If the manuscript contains tables, the main body of the manuscript and references should be saved as one item, i.e., *article*, and then each table should also be saved as a separate item, i.e., *Table 1, Table 2.*

All scientific manuscripts should be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."* Papers will not be considered for publication if they have already been published or are described in a manuscript submitted or accepted for publication elsewhere. All persons designated as authors should have participated enough in the work to take public responsibility for the concept.

Manuscripts should be accompanied by one extra copy, be double-spaced, have each page numbered and should include a title page, an abstract of no more than 150 words, and references numbered consecutively. No more than 10 references will be published and then a statement will appear that the author should be contacted for the other references listed in the manuscript.

Tables, figures and photos should be numbered, and indicated with parentheses whenever they are mentioned in the text, i.e. (Table 1), (Figure 1). Legends should be included for all figures and photographs.

Photos must be unmounted glossy prints in a 5 x 7 format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author at a cost of $13 for each photo. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be created in black and white.

All scientific material is reviewed by the editor and three members of the Publication Committee. Depending on their content, other types of articles are usually only reviewed by the editor and should still be mailed to the same address. All articles should be addressed to: Stephen D. Ward, M.D., Editor, *West Virginia Medical Journal*, Charleston, WV 25364.

If you have questions or need more information, phone Nancy L. Hill, managing editor at (304) 925-0342.

President's Page

Seventh inning stretch

I have now passed the midway point of my term as your president. It has been a hectic six months, but a very rewarding and enlightening time for me.

Since I have completed this milestone in my presidency, I would like to take this opportunity to express some of my feelings and observations:

1. For the first time in years, our legislative agenda is proactive instead of reactive. Although we may not get every bill passed, we have worked very hard to educate legislators on the issues. The legislative briefings which are conducted every Monday morning by our lobbists Nancy Tonkin and Steve Haid have been very beneficial in developing strategies and updating members and staff about happenings at the Capitol. The *Legislative Update* published by the WVSMA has also been invaluable in keeping members abreast of the movement of bills and other key legislative news. We also have interacted more with the West Virginia Hospital Association and other health care organizations this session to find some common ground on some of the issues.

2. We always seem to have the same legislators blocking our bills. Unfortunately, though, I bet that most WVSMA members and most of the citizens of the state do not know who these individuals are and keep voting them back into office. WVSMA members need to be much more knowledgeable about the voting records of their legislators, as well as the health care issues brought before the Legislature so actions taken are more favorable to the practice of medicine.

3. APATHY is our biggest problem. It seems as though the motto of many members is *"I don't have the time — let somebody else do it."* Are you one of these individuals? If you don't have the time, at least join the WVSMA, numbers help. The WVSMA could get much more accomplished if we had more *active members* because doors will open much easier if we work in groups instead of individually.

4. We must have a more active Council. If you are a councilor, come to the meetings or participate in the conference calls. Decisions should be made by more than a handful of physicians. It may be valuable to publish the attendance records for Council meetings.

5. We need to work strongly with the AMA in stopping the HCFA's "Fraud Seminars" from occurring. HCFA and the AARP are sponsoring nationwide seminars to train senior citizens to spot fraud and abuse, and then presenting them with rewards if they provide them with information. There are already numerous systems in place to detect and punish the abuser. This new incentive sounds like the Communist Party idea of having children turn in their parents. HCFA can already identify fraud, so why is this new program being enacted? I can see no reason for this program except to frighten physicians out of providing care for the elderly.

6. The WVSMA staff is great. They have all done an outstanding job of assisting me and I encourage you to utilize their talents. If it wasn't for Nancie keeping everything going, and for Shirleen telling me where to go, I would be lost. I miss Tim Allman, director of operations, and Nidia Henderson, director of government relations, who have recently left to accept new positions, but wish them the best of luck.

7. I want to welcome Evan Jenkins, our new executive director. It was a long search and interviewing process, and an even harder decision. We wished we could have hired all the finalists. We couldn't, so we selected Evan, a legislator and a lawyer who knows West Virginia government well. He is easy to work with and will be a good addition to the WVSMA staff.

As I'm writing this message, the Legislature is in its final days of the session. I hope to have some good news about our legislative agenda in my next message.

David W. Avery, M.D.

Definitions

Tragedy (traj'-a-di), *n.* *{Gr. tragodia}.* 1. A serious play having an unhappy or disastrous ending brought about by the characters or central character impelled, in ancient drama by fate or, more recently, by moral weakness, psychological maladjustment, or social pressures.
(Webster's New World Dictionary Of The American Language, Copyright 1951, 1952).

Do you like dictionaries? Some words, once defined, defy redefinition regardless of the status or high office of someone intent on distorting word meanings as in some Orwellian nightmare. Dictionaries, generally, are comforting, imparting as they do the reassuring notion that life, along with these words, is, to a major extent, predictable.

Some definitions give alarm. The above might be an example. We have heard, "Oh, but it's just a definition. It's something old, probably not modern. The Greeks were like that, you know. They liked that heavy stuff. I like things with happy endings like on TV and in the movies." Just so.

Well, where is the happy ending to our present presidential problem with Monica stories hanging about the necks of all of us like some dead albatross? Since he was found not worthy of conviction on impeachment charges, should we just go on happily watching ever ascending tickertape scrolls while we blithely buy up the rest of the world?

But some of us worriers are probably just cursed with an old fashioned hangup that says that punishment always follows sin. Perhaps so. And perhaps, too, we do not watch enough TV or go to the movies often enough to appreciate the joys and benefits of happy endings. Is there anyone around willing to question the fact that by any definition we have a huge moral problem in the White House? If such a one exists, he must be too timid to show himself.

How about the "psychological maladjustment" mentioned in the above definition? It is surprising to find that no effort has been made to explain away Mister Clinton's alarmingly uncontrolled passions and willingness to lie about them by the usual glut of psychologic apologists always ready and anxious to absolve the least or the worst perpetrators and their crimes.

It might not be the politically correct thing to do, but surely it would be easy to look into the past of a small town Arkansas boy and posit some dark and seamy experience with an abusive parent, classmate, coach or teacher, perhaps a cruel and brutal officer of the law upon whom to blame that boy's unfortunate failings. Perhaps then a few weeks of counseling at a mental health center would be appropriate and satisfy everyone's concerns.

There is a good, old-fashioned diagnostic psychiatric term, no longer used, which encompassed many of the descriptions of our leader. The use of the term psychopathic personality was discontinued 30 odd years ago because of the many pejorative connotations attending its use. Try looking that one up in your dictionary.

Social pressures? Oh my, yes. All those right-wing conspirators out there calling him bad names! An unfriendly Congress! And how about that virago to whom he is married? It must be a living hell to put up with someone like that.

Someone in the Administration had best get busy writing a happy ending for this show. It is hardly likely that it will mutate into an American comedy, although many European observers can find no other way of viewing the present Washington scene than as just that. Failure to convict on impeachment charges in the Senate is not a happy ending or even progress on a script writer's effort toward that end.

Webster gives us three choices to account for our Washington tragedy. You may take your pick.

Stephen D. Ward, M.D.
Editor

New editors

The masthead of this issue of the *Journal* displays two significant and noteworthy additions. The list of associate editors this month shows the names of James D. Helsley, M.D., and Jeffrey B. DeBord, D.O.

Dr. Helsley is known to WVSMA members as a past president, as an AMA delegate, and as chairman of the Committee on Medical Education. Dr. DeBord, who joined the WVSMA in 1992, practices internal medicine in Martinsburg and recently served as vice president of the Eastern Panhandle Medical Society. Please see the article on page 83 for more information about these two new associate editors.

We welcome both Dr. Helsley and Dr. DeBord and look forward to their editorial comments. We also regret the resignation of Harvey D. Reisenweber, M.D., and thank him for his many years of service.

Legislative Day

Highlights of the WVSMA's Legislative Day at the State Capitol included: A hearing on the liquidation of PIE Mutual Insurance Company where WVSMA President Dr. David Avery *(top left)* and Dr. Michael Fortunato of Wheeling *(bottom right)* were among the physicians to testify. *(Top right)* A group photo with Governor Cecil Underwood and Delegate Gil White for many of the physicians and Alliance members in attendance. *(Center)* A briefing with Delegates Gil White *(standing),* and J. D. Beane and Karen Facemyer *(seated). (Bottom right)* The chance for WESPAC Chairman Dr. Douglas McKinney *(right)* and Dr. Muthusami Kuppusami of Welch *(left)* to meet with Delegate Richard Flanigan of Mercer County.

(Top left) House Government Organization Committee Chair Vicki Douglas emphasizes a point while talking with Dr. Constantino Amores at the WVSMA's Legislative Reception. *(Top right)* Speaker of the House of Delegates Bob Kiss *(third from right)* and Delegate J. D. Beane *(left)* discuss issues with several physicians. *(Center)* The Embassy Suites was the site of this year's well-attended Legislative Reception, as well as the WVSMA's Mid-Winter Clinical Conference. *(Bottom right)* Senator Shirley Love chats with WVSMA Lobbist Nancy Tonkin and Bill Perry. *(Bottom left)* Dr. Michael Fidler gestures as he explains his views to Kanawha County Senator Brooks McCabe, Kanawha County Delegate Art Ashley, and Dr. Richard Rashid.

Special Report

The first five years: A review of the collaboration between DHHR and the WVU School of Medicine

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Abstract

In 1992, the West Virginia Dept. of Health and Human Resources (DHHR) and the West Virginia University School of Medicine, Dept. of Behavioral Medicine and Psychiatry (BM & P), entered into a collaborative effort to provide treatment for patients at the state-operated psychiatric hospital in Weston, W.Va. Within five years, patients were moved into a new, modern facility renamed the William R. Sharpe Jr. Hospital, which is JCAHO approved and Medicare certified; the clinical and nursing staff has increased by 38%; and students from a variety of disciplines rotate through for training. In addition, 70% of all patients admitted are discharged within 20 days or less.

Introduction

West Virginia's state mental hospital system consists of two hospitals, one located in Huntington serving the mental health needs of the southern part of the state, and other is located in Weston, serving the needs of central and northern West Virginia.

Individuals who are found to be a danger to self or others by reason of mental illness are admitted involuntarily to one of these hospitals for an evaluation period of up to 10 days. If the mental illness and the potential for "dangerousness" is confirmed on initial evaluation, the patient is then legally "committed" to the facility for an extended period of time for treatment.

Goals

Chronic inadequacies in professional resources reached crisis proportions in the 1980s and early 1990s, and Weston Hospital found itself lacking sufficient clinical staff to provide quality treatment for patients.

Despite reductions in patient census during the 1970s and 1980s, the average daily census in 1991 was 264 patients with 1,698 admissions for the year. The average length of stay was 73 days. Although there were eight physicians working at the hospital, only one was a psychiatrist. The hospital was not and had never been JCAHO approved. In addition, vigorous efforts to recruit additional professional staff had proven futile.

Meanwhile, during the 1980s and 1990s, the WVU School of Medicine was emphasizing community outreach. The Department of Behavioral Medicine and Psychiatry (BM & P) was looking for opportunities to meet the growing need for quality public mental health care. A Public Sector Division was created within the department and one of its initial focuses was on the state mental hospital system.

There was an awareness with BM & P that the changing reimbursement climate within managed care would eventually impact negatively on the psychiatry residency training program. New opportunities and approaches to residency training would be needed.

In October 1992, the benefits of a collaborative effort to both Weston Hospital and BM & P were apparent, so the WVU School of Medicine entered into a contract in which BM & P would provide clinical professionals, management and direction to the hospital. The agreed upon goals were to have the hospital become JCAHO approved and Medicare certified, as well as to provide state-of-the-art care to patients. The hospital was to eventually become a center for teaching and research.

Accomplishments

The collaboration began with a concerted effort by BM & P to recruit academic clinicians to work at Weston Hospital. By December 1997, there were 12 physicians on the medical staff, nine of whom were psychiatrists. The medical staff also includes two physician assistants.

Social workers increased from 12 to 19 during the first five years and the credentials of the additional staff

qualified them for academic appointments at WVU. Psychologists increased in number from two to five, and all of the psychologists who were hired had their doctorate degrees. All received academic appointments in the WVU School of Medicine.

The recruitment efforts of the hospital also played a significant role in upgrading the quality of patient care. Although the number of LPNs remained constant from 1991 to 1997 (33), the number of RNs increased from 32 to 58.

As expected, the addition to professional clinical staff resulted in improvement in the patient care. In 1995, the hospital passed the JCAHO accreditation for the first time in its 125-year history. Shortly after receiving JCAHO accreditation, the hospital also obtained Medicare certification. Passing both of these quality-care assessments, opened the door for reimbursement opportunities for the hospital that had not been available previously.

A move to a new, modern hospital facility in May 1994 permitted further developments in quality patient care. The statistics showed the dramatic change in patient care. In 1997, 70% of all patients admitted were discharged in 20 days, whereas in 1991, the average length of stay for patients had been 73 days.

Third-year medical students from the WVU School of Medicine and from the West Virginia School of Osteopathic Medicine have been regularly rotating through Sharpe Hospital for their psychiatric training since 1997. WVU residents in psychiatry spend two months at Sharpe with an option of additional elective time. In addition, physician assistant students from Alderson Broaddus College and medical students from Marshall University also utilize Sharpe as a training site, so it has become a significant medical education setting.

A hospital-based Research Committee, working closely with the WVU School of Medicine's Institutional Review Board (IRB), has now been active for the past two years. Early reasearch projects have focused on issues of quality patient care. For example, a study done on the Young Adult Unit found that adverse incidents (acting out, elopement, self abuse) were more likely to occur if the unit's young adult patient population exceeded seven (1). As a result of this study, no more than six young adults are housed together.

Difficulties

While improved patient care and increased educational opportunies have resulted from the collaboration, this partnership has produced tension and, on occasion, conflict among participants. State hospital employees, many of whom had been caring for patients for decades, were doubtful of the "academic types" who came in to run "our hospital." Faculty members who went to Weston struggled with a perceived "resistance to change."

Not unexpectedly, the merger of two different cultures (state hospital and academic) was turbulent. In the first five years, there were three hospital administrators, three clinical directors and two directors of nursing. The director of every clinical department changed at least twice and the turnover in the medical, clinical and nursing line staffs was significant. In addition, patients who had been hospitalized at Weston before the collaboration when the atmosphere was more lax with very few treatment opportunities, had difficulties meeting staff's expectations that they be involved in "therapy."

Fortunately, after five years, these tensions and problems with both staff and patients have been resolved. A common goal of improved patient care has united the civil service and academic clinical staffs, and 70% of patients admitted are compliant with treatment and discharged within 20 days or less.

Discussion

Five years ago, Weston Hospital and the Department of Behavioral Medicine and Psychiatry entered into a collaborative effort to improve the quality of patient care for those individuals with severe, persistent mental illness and to increase educational opportunities for clinicians-in-training. Both goals have been realized.

Nevertheless, ongoing efforts continue toward improving the quality of care rendered to patients and to enhance training for students and residents.

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Quinine: The conquest of malaria and the beginning of the modern drug industrial complex

JAMES E. BRICK, M.D.
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Introduction

Quinine is the chief alkaloid of cinchona, the bark and genus name of several plum size species of trees indigenous to the Andes mountains in what is now Equador. No other drug has played such an important enabling role in the European exploration and conquest of the tropical and and subtropical areas of this planet.

Arguably, the early use of quinine represents the first documented large scale drug trials in antiquity and the beginning of the single source domination of the world pharmaceutical industry. This article addresses the development of quinine including its discovery, its mechanism of action, and its place in history.

The rival histories

At least three rival stories compete for the honor of first introduction of cinchona in the Old World, and, it will probably never be known which resembles the unvarnished truth. Each of them add a touch of romance to a drug of tremendous historical importance.

The first written account of cinchona appeared in 1639 from the hand of an Augustan monk named Antonio Calancha who described a powder made in 1633 from the bark of what the Indians called "the fever tree." This powder was used in the area around Lima to cure "fevers and tertians" (i.e. malaria). This account recalls that the natives of the area were aware of the compound's specific medicinal values, which seems quite logical, but has really been impossible to fully document by any scholar of cinchona's history . . .

The most romantic tale and the one most cited is the malaria cure of the Countess of Chinchon Ana De Osoriio, who was the wife of the Viceroy of Peru in 1638. Unfortunately, Countess Anna died in 1625 three years before her husband became Viceroy and this wonderful story is no doubt untrue. It is clear though that the count's agent was selling the bark at a pretty price in Seville by 1640. Nevertheless, Linnaeus named the tree cinchona as a misspelled derivative of Chinchon and her name lives on.

The final and third account involved the observation by Jesuit priests of the bark in use by the Indians, not in the treatment of malaria, but to alleviate the shaking chills they experienced after fording mountain streams to work in mines near Quito. Some authorities in this tradition hold that the antimalarial property of the bark was wholly unknown to the natives, and that the Jesuits, seeing the possibilities in the treatment of chills and shivering seen in Tertians and Quartans made the step toward malaria.

In any event, by the second half of the 17th Century, it was clear that the bark had made its way to Europe where malaria was widespread. In Spain and Italy, cinchona was under the sponsorship of princes and the Catholic Church, where it was being tested on large numbers of patients with malaria and other disorders in order to settle questions of dosage and efficacy. Very few details of these studies survive, but Cardinal Luigo, one of the princes of the Catholic Church in Rome, was particularly associated with these experiments, hence the name "Cardinal's bark." The association with the Catholic Church, and distrust of the Jesuits in particular because they profited from the trade in the bark for decades after its introduction via a near monopoly, no doubt contributed to cinchona's slow acceptance in Northern Europe despite the fact that the Church gave much of this material away.

A brisk trade grew up between the New World and the Old and an aggressive smuggling operation developed, reminiscent of that which is still present in the world today for cocaine. Exports of the tree or seeds was forbidden; and unlike the situation with opium, the production of cinchona was largely confined to one corner of the world and largely under the control of Spain and the Catholic Church.

Any product associated with as much potential profit, limited supply, early confusion in identification, and political-religious controversy, was a ripe situation for abuse and that is just what was seen in the 1700s. Anti-catholic sentiment, adulteration of product, and accusations of price gouging all took place. Like colchicine, it was included in a whole host of preparations of dubious, sometimes even toxic nature marketed in the century after coming to the Old World.

Despite these difficulties though, the word on the bark did spread. Eventually, it was shown that cinchona:

1. worked essentially only for malaria, though it was later discovered that the bark could also be used to control palpitations (no doubt related to the inclusion of quinidine in the mixture of alkaloids that it contained).
2. could be given prophylactically in some cases to prevent attacks.
3. was actually a curative and was not just a giver of symptomatic relief, years before the malaria parasites were described.

The religious controversy surrounding the bark, as well as its high price, lead the Reverend Edmond Stone of the Royal Society in England to use the bark of salix (willow) instead of cinchona to treat fevers and arthritis in his country. This effort by Reverend Stone began the large scale use of salicylates and hence the development of other non-steroidal anti-inflammatory drugs.

The value of quinine

The component of cinchona of most interest is quinine, which has a number of actions. In addition to its antimalarial actions, quinine inhibits a number of enzymes including cholinesterase, has analgesic and mild antipyretic properties, as well as potent effects at neuromuscular junctions.

Conclusion

Though quinine is no longer of as much value in the treatment of malaria, its analogs are still widely used and much can be learned from the economic, religious and historical features surrounding the discovery and use of cinchona throughout the world.

It is also interesting that this all began in a part of the world where we now focus on the trade of another drug from coca leaves, which were discovered and apparently widely used by indigenous peoples generations before Europeans entered the area.

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Terminate with caution: Ending a patient relationship requires special care, documentation

Q. For what reasons can I terminate a relationship with a patient? Are there any standard procedures I should abide by when terminating a relationship?

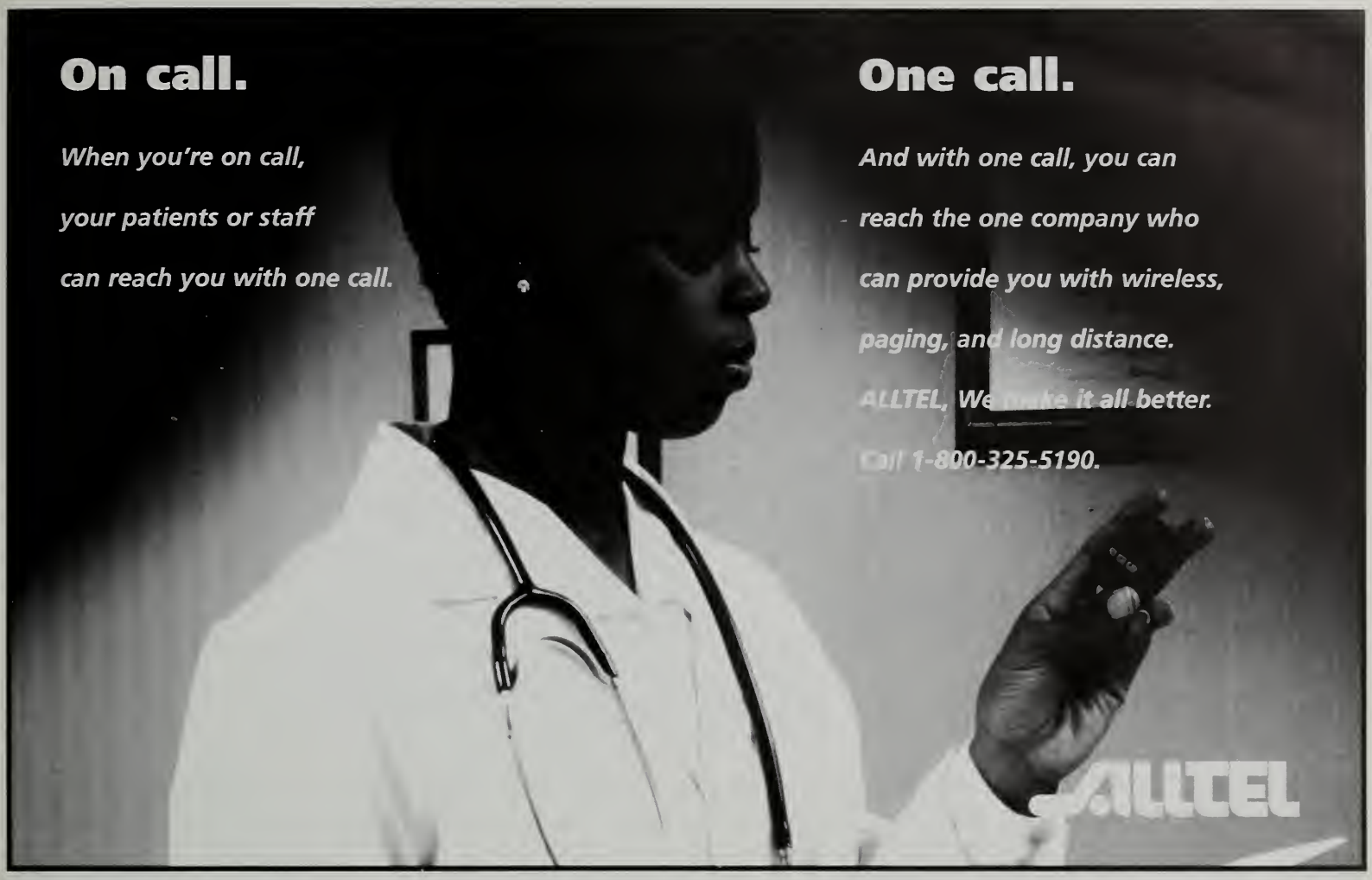
A. When you establish a relationship with a patient, you also take on the duty to treat the individual until the relationship is terminated. Termination can occur for several reasons and either the patient or the physician can initiate termination. Physicians can withdraw from a patient relationship if the patient is not complying with recommended treatment or if the patient fails to meet financial obligations. In addition, a patient relationship can be terminated if a physician is retiring or relocating his/her practice. The one instance in which the physician cannot terminate the care is in an emergency. However, ending a relationship with a patient could lead to an abandonment claim by the patient. A clear, concise, well-documented termination with reasonable notice will fortify the physician's defense.

Remember, each termination should be viewed and treated on an individual basis. Consideration of the patient's medical problem and the availability of qualified care should be given before terminating care with the patient. When possible, the physician then should personally discuss the reason for terminating care with the patient. After speaking with the patient, a written notification should be sent, via certified mail, confirming the termination of care. The discussion and the letter's mailing should be documented in the patient's record.

The discussion with the patient, documentation in the record concerning the discussion and the termination letter should include the following:

- **Referral sources to obtain new medical care**
  For example, a county medical society.
- **Amount of time that treatment will continue**
  A reasonable length of time should be provided for the patient to arrange services by another physician. In most situations, 30 days notification to the patient is adequate. In some cases, this length of time may not be appropriate due to the patient's present health condition.
- **The procedure for obtaining a copy of the patient's medical record**
  This can be done upon receipt of a written request (a free copy is recommended). Generally, copies of the record should not be withheld if the patient has not paid for all previous services. Physicians also should consider the requirements or terms pertaining to any payment or agreed contracts.
- **Information concerning the patient's health if the patient has an illness which may require follow-up care**

Physicians insured by Medical Assurance, WVSMA's endorsed professional liability carrier, may contact the company's Risk Resource Center for answers to liability and/or risk management questions by calling (800) 282-6242 or via e-mail at rmhelp@maih.com.



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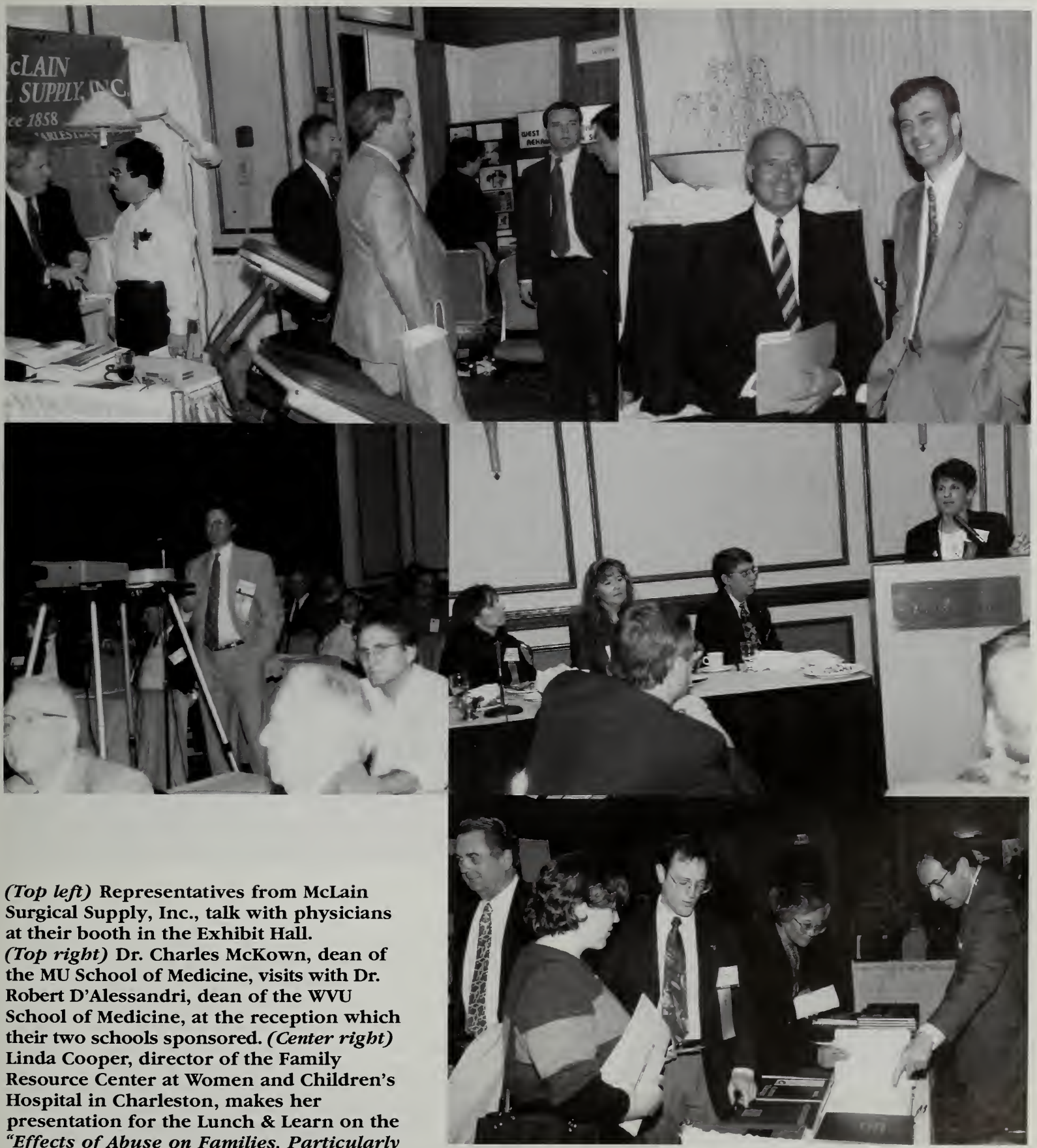
WVSMA's Mid-Winter Clinical Conference

(Top left) **Dr. Timothy Deer of Charleston emphasizes a point as he lectures about *"Patient-Centered Pain Management at the End-of-Life,"* during the Third Scientific Session. *(Top right)* Dr. Eben Alexander of Boston (*right*) happily poses with Dr. Constantino Amores after presenting a fascinating lecture entitled *"X-Knife: A Neurosurgery Update."* Dr. Amores was instrumental in obtaining Dr. Alexander as a speaker for the Mid-Winter Clinical Conference. *(Center right)* Charleston psychiatrist Dr. Jerome Massenberg gestures as he answers a question during the panel discussion for the Physician/Public Session on *"Violence in the Home Becomes Violence in the Streets."* The other speakers pictured are Dr. Cindy Christian and Sergeant Tom Westfall. *(Bottom)* Dr. Frederic Regenstein of Tulane University presents his lecture entitled *"Overview of Viral Hepatitis A-G"* for the First Scientific Session. *(Center left)* Dr. Sue Warren and Dr. Alvin Moss respond to a participant's question during the Third Scientific Session on improving end-of-life care.**



(Top left) Representatives from McLain Surgical Supply, Inc., talk with physicians at their booth in the Exhibit Hall. *(Top right)* Dr. Charles McKown, dean of the MU School of Medicine, visits with Dr. Robert D'Alessandri, dean of the WVU School of Medicine, at the reception which their two schools sponsored. *(Center right)* Linda Cooper, director of the Family Resource Center at Women and Children's Hospital in Charleston, makes her presentation for the Lunch & Learn on the *"Effects of Abuse on Families, Particularly Children." (Bottom)* Dr. Araceli Almond Ganan, Steve Greer, president of the WVSMA Medical Student Section, and WVU med student Hannah Hazard look over books with David Prox at the W. B. Saunders booth. Pictured in the background is Dr. William Morgan of Charleston. *(Center left)* WVSMA President-Elect Dr. Phillip Stevens poses a question during the panel discussion for the Third Scientific Session.

(Top left) **Dr. Bill Atkinson and his wife, Carolyn, enjoy the zany antics of the band Bob Noone & The Well Hung Jury, who entertained at this year's meeting.** ***(Top right)*** **Sporting his Carmen Miranda headgear lawyer Bob Noone and his band play a tropical tune for the guests at the reception hosted by Medical Assurance and Acordia of West Virginia.** ***(Center)*** **Guests formed a conga line as they got into the dancing spirit with music provided by Dr. Rano Bofill.** ***(Bottom left)*** **Singing sensation Dr. Florencio Neri was a highlight for guests when he performed after the band.**

(Top left) Scott Atkins of Acordia got into the act with the band when he put on a neck brace and held up a sign with the phone number of lawyer Bob Noone, the leader of the band, during a song about Bob's law practice. *(Top right)* Tamara Lively and her husband, Gary, enjoy the evenings' festivities. *(Bottom right)* Dr. Rano Bofill sang one of his favorite songs to get the audience in the laser karaoke mood. *(Bottom left)* Christina Dixon, Misty Ramsey and Nancie Albright of the WVSMA joined with Gary Lively and Dr. Stephen Sebert for a laser karaoke number. Dr. Bofill is pictured at right watching the monitor.

(Top left) Dr. Tara Sharma of Huntington presented many fascinating perspectives on the subject of alternative medicine during his lecture for the Second Scientific Session concerning *"Controversies in Medicine."* *(Top right)* Dr. Kevin Yingling of Marshall University uses a flip chart while discussing a case study during the *"Stump the Audience"* segment of the Fourth Scientific Session. *(Center)* Tim Allman presents Dr. Araceli Almond Ganan with the grand prize at the door prize drawings. *(Bottom)* Dr. Donald Teeter was the lucky winner of a door prize which was presented by Dr. Warren Point at the conclusion of *"Stump the Audience."* Pictured in the foreground is Dr. Daniel Foster, chairman of the WVSMA's Mid-Winter Clinical Conference.

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Nebulized nitroglycerin in children with pulmonary hypertension secondary to congenital heart disease

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Abstract

Pulmonary hypertension continues to be a major cause of morbidity and mortality, despite new treatments. Since inhaled nitric oxide has been reported to be effective in some cases, we investigated using nebulized nitroglycerine to treat pulmonary hypertension in children with congenital heart disease. Four children (ages 6-72 months) with severe pulmonary hypertension secondary to congenital heart disease (all with membranous ventricular septal defect, undergoing cardiac catheterization) were given 3 cc of nebulized normal saline over 10 min as placebo control, followed by nebulized nitroglycerine (20μg/Kg in 3cc normal saline). Normal saline administration did not elicit any change, but nitroglycerine administration resulted in the following changes (mean ±SE, paired statistics): systolic pulmonary artery pressure from 68±8 to 53±6 at 10 min into treatment (P 0.006), mean pulmonary artery pressure 47±4 to 38±4 (P 0.005), heart rate 131±8 to 127±7 (P 0.13), systolic blood pressure 85±8 to 88±3 (P 0.7), mean blood pressure 59±6 to 63±4 (P 0.5). These results indicate that nebulized nitroglycerine may be an effective, easy to administer, inexpensive, and safe alternative for treatment of severe pulmonary hypertension in children with congenital heart disease, especially in areas where other treatments such as extracorporeal membrane oxygenation or inhaled nitric oxide are inaccessible.

Introduction

Pulmonary hypertension (PHT) continues to be a major cause of morbidity and mortality in the pediatric age group. One common cause of pulmonary hypertension is congenital heart disease, unless the congenital heart lesions are surgically corrected early in life (1).

Conventional therapy with mechanical ventilation is not always effective and use of intravenously administered vasodilators is limited because of the systemic effects, such as hypotension. Extracorporeal membrane oxygenation (ECMO) can be effective, but it is invasive and not feasible in small hospitals and rural areas. The discovery of the endothelium-derived relaxing factor (EDRF, 2) and its identification as nitric oxide (NO, 3) made it potentially possible to use inhaled NO for treatment of persistent pulmonary hypertension.

Reports of beneficial effects of inhaled NO in infants with persistent PHT (4), as well as in children with congenital heart disease (CHD, 5), are promising. Delivery of inhaled NO, however, requires special equipment (5,6) and may also be toxic.

Many rural areas in the U.S. and the world have no access to either ECMO or inhaled NO. Nitrovasodilators are believed to release NO during their metabolism (7) and thus their vasodilatory mechanism is similar to that of NO.

In this study, we sought to determine if nebulized nitroglycerine (NTG) can be effective in reducing pulmonary artery pressure without significant change in systemic BP in children with pulmonary hypertension secondary to CHD.

Methods

This study was approved by the Research Administration at Zhejiang Medical University Children's Hospital and consent was obtained for each of the four children, ages 6 months to six years. These children were spontaneously breathing with uncorrected ventricular septal defect and severe PHT undergoing diagnostic cardiac catheterization.

Severe pulmonary hypertension was defined as pulmonary artery pressure at least half of systemic blood pressure (Table 1). Baseline pulmonary artery pressure, systemic blood pressure, oxygen saturation, and heart rate were measured. Each patient received 3 cc of nebulized normal saline (NS) as placebo control and these vital signs were recorded at 5 min intervals.

Next, each patient received a dose of 20 g per kilogram body weight of NTG in total volume of 3 cc NS nebulized and their vital signs were recorded at 5 min intervals.

Results

Nebulized NS failed to produce any changes in any of the patients. Nebulized NTG, on the other hand, significantly reduced pulmonary artery pressure without changing the systemic BP or heart rate (Table 2).

This study was terminated at the end of the catheterization procedure with no long-term follow-up.

Discussion

Treatment for severe PHT continues to be difficult and often is not successful, despite the promising role of nebulized NO and ECMO as well as other treatment modalities. The fact that the mechanism of action of nitrovasodilators involves metabolism to NO led us to investigate of their potential.

To study the potential benefits of nebulized NTG on PHT, we selected four stable patients undergoing a diagnostic procedure. The lack of effect of NS eliminated the possibility of a placebo effect when using NTG. The significant reduction of both systolic and mean pulmonary artery pressures is encouraging, knowing that patients with uncorrected VSD tend to have sustained high diastolic pressure which would not respond well to any treatment.

Administering nebulized NTG had no effect on systemic BP or heart rate, presumably because of the fast local metabolism and short half-life. This finding is also promising because of the limitations of any treatments associated with systemic effects.

Conclusion

Nebulized NTG appears to be an effective, easy to administer, inexpensive and safe alternative for treatment of severe PHT in children with CHD, especially in areas where other treatment modalities such as ECMO or inhaled NO are inaccessible.

Table 1. Characteristics of the Four Pediatric Patients.

Age (months)	Diagnosis	Baseline PAP	Baseline BP
72	VSD	80/32	84/51
36	VSD	85/33	93/39
18	VSD	56/35	99/62
6	VSD	45/20	64/34

VSD = ventricular septal defect
PAP = pulmonary artery pressure
BP = blood pressure

Table 2. Effects of Administration of Nebulized Nitroglycerine.

	Before NTG	At 10 minutes	P value
SPAP	68 ± 8	53 ± 6	0.006
MPAP	47 ± 4	38 ± 4	0.005
SBP	85 ± 8	88 ± 3	0.7
MBP	59 ± 6	63 ± 4	0.5
HR	131 ± 8	127 ± 7	0.13

Combined statistics for the four patients. Student's t-test (paired statistics) was utilized.

SPAP = systolic pulmonary artery pressure
MPAP = mean pulmonary artery pressure
SBP = systolic blood pressure
MBP = mean blood pressure
HR = heart rate

Larger studies on similar patients and also on patients with different etiologies are needed to confirm our preliminary findings.

Acknowledgement

We thank Bertha Romine for her secretarial assistance.

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Headache occurrence and classification among distance runners

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Abstract

There has been little research done on headaches in the athletic population. To determine the characteristics, frequency, and the effects of medication and exercise on headache in marathon runners, we conducted a random survey involving 354 male and 118 female distance runners participating in the annual 15-mile and 5K Charleston Distance Run on August 31, 1996. Runners were classified into categories of probable migraine, possible migraine, probable tension, probable cluster and other unclassified headaches using modified International Headache Society criteria. There was a higher proportion of distance runners with migraine headaches compared to the regular population (36% vs. 17%). Running did reduce the severity and frequency of all types of headaches. Sleep eliminated headaches in most of the headache patients. The migraine group had a statistically significant lower age (39.7) and the most headaches per month (3.1) with trends in the most numbers of runners with a previous head injury (n=7) and the most with equipment causing headaches (n=13). Only 5% (n=26) of the runners had sought medical care for their headaches, however, over 180 athletes noted mild-to-moderate symptoms. Since very few runners seek medical care for headaches, physicians need to identify and treat these patients to maximize their athletic abilities.

Introduction

Headache is one of the most common ailments encountered in modern society. Although data is available for the general medical population, there is little information regarding the athletic population.

With the dissipation of stress noted by most active exercisers, one might expect that the incidence of severe headaches might be much lower in this population. To investigate this theory, we studied athletes who were thought to be similar to the typical headache population in that they were runners and most likely had the so-called "type A" personalities. We examined headache incidence, characteristics, treatments, and the effect of treatments on the patient and their ability to exercise.

Methods

After the Institutional Review Board approved the protocol, random subjects were obtained from the Charleston Distance Run, a large, annual 15-mile and 5K road race. Surveys and self-addressed envelopes were enclosed in the registration packets, and a second packet was sent to 200 randomly chosen runners that did not initially return the survey.

Of those receiving surveys, 480 athletes (48%) returned completed surveys. However, one was excluded since there were false answers given (age greater than 100, etc.). Only three athletes (0.3%) that responded to the survey indicated that they never had headaches. The survey was developed from International Headache Society (IHS) criteria for diagnosis of headaches and from the only previously used survey in the sporting population (1).

The survey was designed to be short (only one page) and so that mostly boxes could be checked instead of using essay answers. Data was collected and stored using the SAS program. Subjects were grouped into the following groups (Table 1):

1. Probable Migraine Headaches
2. Possible Migraine Headaches
3. Probable Cluster Headaches
4. Probable Tension Headaches
5. Other Unclassified Headaches

This separation was accomplished using a modified IHS criteria for diagnosis. Statistical methods included analysis of chi-square, student's t-test and the Pearson Correlation Coefficient to check the relationship between amount of running and severity and frequency of headaches.

Results

There were 476 runners who responded to the survey. Of these athletes, 354 were males, 118 were females, and four did not specify gender. Characteristics of the respondents are presented in Table 2.

The mean age was 42 years old (range 10-89 years). The mean miles run per week was 31 miles (range 1-120 miles). The mean headache frequency was 21 per year (range 0-365 headaches per year).

Most runners with headaches reported mild symptoms (64%) vs. moderate (31%) or severe (5%). Although no subject reported headaches as one of their listed chronic medical conditions, 26 (5.4%) runners were taking at least one prescription medicine for the relief of their headaches. Head injuries were reported by 13 respondents (2.7%) as an antecedent event to their headaches.

The probable migraine group included 153 runners (32.6% of the total respondents) (Table 3). There were 101 males, 52 females, and two who listed no gender. Of these runners, 37 reported mild symptoms, 101 had moderate symptoms and 17 indicated severe symptoms.

The mean age of this group was similar to that of the entire population at 39.7 years of age and the mean mileage was 32 miles per week. Mean headache frequency for this group was 3.11 headaches per month. Seven patients reported a previous history of head injury. Very few subjects noted problems with exercise causing exacerbation of symptoms. Only seven of the group reported increased severity of headaches with running and only eight had increased frequencies with running. However, 58 noticed a decreased frequency when doing regular aerobic exercise and 42 noted a milder headache when running regularly.

More than a third of this probable migraine group had a family history of vascular headaches (54 of 145) which was significantly different than other headache groups (p=.040). Thirteen of the group noticed that equipment sometimes exacerbated symptomatology and a majority noted sleep relieved headaches (107 of 152, 70%). Exacerbating factors included caffeine use, cheeses, chocolate, MSG, and Nutrasweet. Relieving factors also included caffeine and hydration with water.

The possible migraine group included 55 runners (42 male, 13 female, 11.6% of the respondents) (Table 3). The mean age was 46 and mean mileage was 33 miles per week. The headache frequency was one per month. Almost all the runners classified their headaches as mild (n=36). The remainder classified them as moderate (n=4) or severe (n=2). Only one admitted to a precipitating head injury.

Exercise was again noted to have a positive effect on the frequency and severity of headaches for most runners. Fourteen of this possible migraine group noted a decrease in frequency when running compared to one with increased frequency. Seventeen noted a decreased severity when the headaches occurred due to running compared to one with increased severity. Eight had a positive family history of significant headaches. Four noted problems with equipment causing headaches and sleep relieved the headaches in 27 athletes.

The tension headache group had 41 subjects (8.6% of total respondents) (31 males, 8 females and two noted no gender) (Table 3). The mean age was 41.6 years old and mean mileage was 30 miles per week. The mean headache count was 2.5 per month. Thirty-three considered their headaches mild and the rest classified them as moderate (n=8).

Exercise seemed to have a positive effect on the headaches in most subjects. Twelve had decreased frequency with exercise and 12 also had decreased severity. Only one noted increased frequency and severity. The majority felt that sleep relieved the headaches (n=36). Only three noted that equipment caused the headaches.

Table 1. Modified IHS Criteria to Group Headaches.

Probable Migraine Headaches

A. Headache length 4-72 hours
B. Headache has at least 2 of these:
   1) One sided
   2) Throbbing
   3) Moderate or severe intensity
   4) Aggravated by exercise in any stage or in later stages
C. During headaches one of these occur
   1) Nausea/Vomiting
   2) Bothered by lights or sounds
D. Have to have A, B, and C
E. Anyone successfully using Imitrex or with visual scotoma

Possible Migraines (one of below)

A. Anyone with only B and/or C from above
B. Headaches generally not relieved by OTC meds
C. Anyone in family having similar headaches

Cluster Headaches (Must have A, B, and C)

A. Knife-like and one-sided
B. One of the below:
   1) Red eyes
   2) Watery eyes
   3) Stuffy or runny nose
   4) Facial/ forehead sweating
   5) Droopy eyelids
C. Frequency of headaches from 1 every other day to 8 per day

Tension Headaches

A. At least 2 of the following:
   1) Both sides of head
   2) Constant, band-like pressure
   3) Not aggravated by exercise
B. Both of below:
   1) No nausea or vomiting
   2) Not bothered by lights or sounds or at least not both

There were no cluster headaches found, so the last category was otherwise unclassified headaches (Table 3). This was the largest group of respondents (n=225, 47.5%). There were 180 males and 45 females. The mean age was 43 and mean mileage 29.6 mile per week. The mean headache frequency was 1.3 headaches per month. Most subjects described them as mild (n=174), and sleep relieved most subject's headaches (n=148). Only four of the group noted head injuries.

Exercise was again noted to lessen the frequency of headaches in 70 subjects, and it decreased the severity in 58 subjects. There was increased severity in only four runners and increased frequency in nine runners.

A multivariate analysis was performed to look at the relationship between headache frequency, type of headaches and miles per week with and without age as a factor. There was a significant difference in age between the headache groups. The older runners with headaches were found more in the possible migraine group and other groups, while younger athletes were classified in the probable migraine and tension groups ($P < .05$).

Table 2. Demographics of Study Population.

Sex
Male = 354 (75%)
Female = 118 (25%)

Age
Median = 41.5 yrs
Mean = 42 yrs
Range = 10 to 89 yrs

Mile/wk of running
Median = 29 miles
Mean = 31 miles
Range = 1-120 miles

Headaches/yr.
Median = 24
Mean = 21
Range = 0-365

Headache severity
Mild = 280 (64%)
Moderate = 134(31%)
Severe = 21 (5%)

Other Medical Conditions
N = 33 runners
No significant chronic conditions N = 440
Ankylosing spondylitis N = 1
Asthma N = 4
Depression N = 1
Diabetes N = 1
Epilepsy N = 1
Fibromyalgia N = 1
Hypoglycemia N = 1
Hypertension N = 19
Thyroid conditions N = 4

Table 3. Characteristics of Each Headache Group.

Headache Type	Poss Migraine n = 155	Prob Migraine n = 55	Tension n = 41	Other n = 225
Age	*39.7	*46	41.6	43
Mileage	32 mpw	33 mpw	30 mpw	29.6 mpw
Headaches/mo.	*3.1	1.0	*2.5	1.3
Head injury	7 (4.5%)	1 (1.8%)	1 (2.4%)	4 (1.7%)
Effects on headache				
(Frequency)	58 (37.4%) noted ↓	14 (25.5%) noted ↓	12 (29.3%) noted ↓	70 (31%) noted ↓
(Severity)	42 (27.1%) noted ↓	17 (30.9%) noted ↓	12 (29.3%) noted ↓	58 (25.8%) noted ↓
Sleep (Sleep relieves)	107 (70%) yes	27 (80%) yes	36 (87.8%) yes	148 (83%) yes
Equipment	13 (8.4%)	4 (7.3%)	3 (7.3%)	

* = significant difference

Discussion

Individual cases of exertional headaches have been described in the medical literature several times in the 1900s. However, the incidence and description of headaches in athletes at any time has not been well studied.

It is has been hypothesized that regular aerobic exercise may be of some benefit in the management of chronic headache due to its many physiologic and psychologic effects. This idea has been supported by at least two studies (2). A more recent study showed a trend of decreased duration, severity and frequency of migraine headaches after a six-week aerobics program in 11 patients, but not in their nine controls (4). However, due to the small numbers of patients entered the differences did not reach statistical significance.

Incidences of exercise-related headaches have been reported (1,5,6), but little mention was made in these reports about headaches that the athletes suffered at other times. William's first study showed a lesser prevalence of non-sports related headaches among physical education majors, 24 of 61 males (39%) and 53 of 90 females (59%), compared to less fit med students, 42 of 86 males (49%) and 39 of 58 females (67%) (1).

William's second study (5) revealed that spontaneous migraines were experienced by 55% of subjects who had exertional headaches and a positive family history was present in 64%. This study hypothesized that aspects of basic migraines are thought to be related to low oxygen tension since the syndrome was prevalent at the Mexico Summer Olympics in 1968 because of the high altitude (7,8).

However, we wanted to investigate all types of headaches in runners not just exertional headaches. The prevalence of migraine headaches in the general population is 17.6% in females and 5.7% in males (9). Our incidence was higher at 32.6%, but this may be due to selection bias by asking individuals at presumedly higher risk (i.e. type "A" individuals) and also the fact that headache surveys are most likely to be answered by those with headache problems. It does seem clear that about one third of athletes noted improvement in symptom frequency and severity with aerobic exercise irregardless of the type of headaches.

There were a majority of patients (about 70%-88% of all types) who noted sleep relieved most of their headaches and several (7%-8%) who experienced exacerbations with equipment used during events also without regard to type. There did not seem to be a proportional relationship between an increase in mileage run to a decrease in the headache frequency and/or severity.

Conclusion

In this population, it seems as if vascular headaches are at least as common, if not more common, than in the general population. However, aerobic exercise, at least subjectively, seems to reduce the number and severity of all types of headaches and should be included in any treatment program as a preventative aid.

Unfortunately, only 5% of our total athletic population had sought treatment for their headaches despite 187 (almost 40%) runners noting moderate-to-severe symptomatology.

Hopefully, better awareness that athletes seem to suffer at the same rate as non-athletes may get them to see a physician for prophylactic and/or abortive therapies that will not compromise athletic endeavors.

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Surveillance testing in patients with primary malignant melanoma

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Abstract

There are, at this time, no fully published prospective randomized studies of follow-up strategies for patients with primary malignant melanoma. However, four recent retrospective studies indicated that greater than 90% of melanoma recurrences were detected by history and/or physical examination, and that detection of recurrent melanoma by blood tests, chest X-ray, or CT scan rarely led to long-term survival. Based on the results of the above studies, recommendations for follow-up as developed by the National Institute of Health Consensus Panel on Early Melanoma can be considered. These include:

1) ***history and physical examination (including total body skin examination) at regular intervals;***
2) ***the consideration of initial screening for first degree family members of patients with melanoma; and***
3) ***on-going education for patients to recognize the signs of local and regional recurrences.***

Introduction

Postoperative surveillance for malignancy is directed toward detection of recurrence, identification of new primary neoplasms, and patient reassurance. Controversy exists regarding follow-up of patients with more common malignancies such as breast carcinoma because detection of asymptomatic recurrences adds little to overall survival in several studies (1,2).

The long-term, disease-free survival rate for patients with metastatic melanoma is low, even when the recurrence is resectable or treated with chemotherapy (3,4). The aim of this paper is to review the literature pertaining to the value of specific follow-up tests after wide excision or resection for primary melanoma.

Role of routine blood/X-rays

A number of recent retrospective studies have indicated that routine blood tests, specifically complete blood count (CBC) and liver function tests (LFTs) and chest X-rays have limited value in the postoperative follow-up of melanoma patients.

In a study by the North Central Cancer Treatment Group (5), the effectiveness of follow-up tests for signaling recurrences was evaluated in 261 patients with resected local ($\geq$ 1.69 mm) and regional nodal malignant melanoma who were enrolled in a single prospective adjuvant treatment trial. All patients were followed for at least five-years. Each follow-up visit consisted of a history, physical examination, CBC, LFTs, and chest X-ray.

Of the 261 patients, 145 patients developed recurrent melanoma. The history and physical exam led to the diagnosis of recurrence in 94% of these patients. Nine patients (6%) with recurrent disease had abnormal chest X-rays. Only one of these nine remained recurrence free for an extended period (58 months) after surgical resection of the metastatic lesion. Laboratory results were never a sole indicator of recurrent disease.

In a study by Jillella et al (6), 279 patients with stages I-III melanoma after definitive surgery (as defined by the American Joint Commission on Cancer) were repeatedly educated regarding signs and symptoms of recurrence. These patients were followed with history and physical examination, CBC and LFTs every 3-6 months and chest X-rays every 6-12 months. Despite the intensive follow-up, 94% of all recurrences were detected by the patients themselves. The authors concluded that in carefully instructed melanoma patients, first clinical recurrences are usually detected by the history and not by routine follow-up lab tests.

In the study by Shumate et al (7), 195 patients with recurrent melanoma were retrospectively stratified according to the type of return visit. Group I returned on a previously determined date, whereas group II returned before the scheduled visit. History and physical examinations were scheduled every three months for years one and two, every six months for years three to five, and yearly thereafter. Chest X-ray and CBC/LFTs were obtained every six months for years one to three and then annually thereafter. Recurrences were symptomatic, thus elicited by history, in 90% and 93% of group I and group II patients, respectively, and correlated with site of recurrence in more than two-thirds of cases. The loco-regional disease-free interval and survival rate were the same for both groups. The authors concluded that overall survival is not affected by routine laboratory and radiographic testing or by the type of patient return visit.

In a study by Basseres et al (8), the cost effectiveness of radiologic surveillance for detecting recurrences was evaluated in 528 patients with stage I melanoma. All were followed for at least two years. Each patient received a history and physical exam, chest X-ray, and abdominal ultrasound or abdominal CT scan twice yearly. Of the 528 patients, 115 relapsed; 90% of relapses were detected by history and/or physical examination. Chest X-ray or abdominal ultrasound revealed only 10% of relapses. Only two of these patients had resectable disease.

Role of nuclear scanning

A number of studies have indicated the limited utility of nuclear scintigraphy in detecting metastatic melanoma in asymptomatic patients.

Roth et al (9) reported on the yield of bone, brain and liver scans in the follow-up of 58 patients with nodal metastases and identified only one patient with a true positive bone scan. Thomas et al (10) also evaluated bone, brain, and liver scans and found no distant metastases in 48 patients with nodal disease at presentation.

In addition, Kuvshinoff and colleagues (11) noted only one true positive bone scan in 62 patients who had this test performed.

Recommendations

As indicated by the three studies mentioned, routine radiographic (i.e., chest X-ray or bone/liver scan) and laboratory (CBC, LFTs) studies to search for asymptomatic distant metastases are difficult to justify. Since some patients are salvaged with wide excision of a local recurrence or lymphadenectomy for a regional recurrence (11), a thorough periodic physical examination by an experienced physician is essential for postoperative surveillance.

Choice of interval between exams is arbitrary, but recommendations developed by the National Institutes of Health (NIH) Consensus Development Panel on Early Melanoma can be considered (12). These recommendations include:

1. Follow-up examinations every six months for two years, then yearly thereafter for those without atypical moles or family history of melanoma;
2. Follow-up examinations every 3-6 months for 2-3 years, then less frequently thereafter for those with atypical moles, a positive family history, or melanoma with poor prognostic features (i.e., lesions > 1 mm in depth and/or that are ulcerated);
3. The consideration of initial screen for first degree family members of all patients with melanoma. The intervals between physician visits could be safely lengthened without influencing overall survival if patients are educated to recognize the signs of local, in-transit and regional recurrences (i.e., increasing size, change in color, or ulceration of a nevus), because they are the most common sites of recurrence and are readily detectible by the patient.

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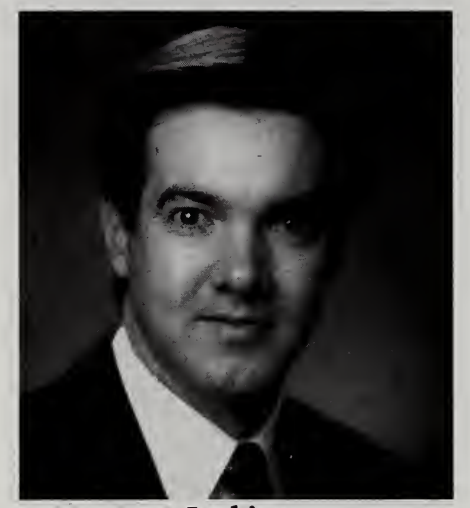
Evan Jenkins named new WVSMA director

Evan H. Jenkins, who has been the general counsel for the West Virginia Chamber of Commerce since 1992 and has served as a member of the West Virginia House of Delegates since 1994, has been named the new executive director of the West Virginia State Medical Association.

Evan is a member of the board of directors for Leadership West Virginia and the West Virginia Council of Economics in Education. He is the founder of West Virginians for a Secure Future and is also the co-founder of Citizens Against Lawsuit Abuse (CALA).

A native of Huntington, Evan graduated from the University of Florida in Gainesville in 1983 with a B.S. degree in business administration and then pursued a master's degree in business administration at Marshall University. He left Marshall to attend law school at Cumberland School of Law in Birmingham, Ala., where he received his juris doctor degree in 1987. He practiced law in Huntington from 1987-1992 with the firm of Jenkins, Fenstermaker P.L.L.C., before accepting his position as general counsel with the West Virginia Chamber of Commerce.



Jenkins

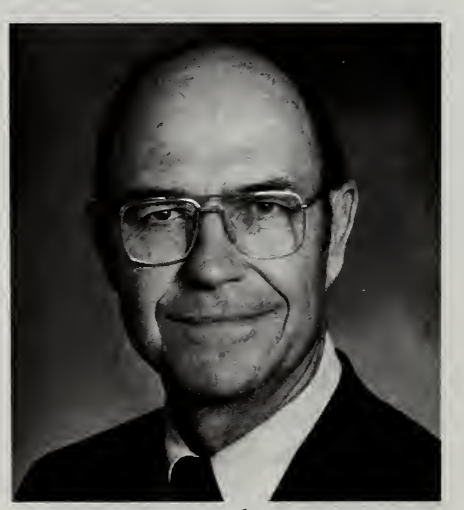
Evan and his wife, Elizabeth, live in Huntington with their two sons. Active in many civic and community organizations, Evan is a past president of Big Brothers/Big Sisters of the Tri-State, and serves on the board of directors for Cabell County Community Services, Huntington Main Street, Operation B.E.S.T. (Business and Education Succeeding Together) and Riverview Manor. He is also an elder in the First Presbyterian Church of Huntington.

Evan begins his new position at the WVSMA on April 5. He replaces George Rider, who left the WVSMA in December.

AMA president to speak at Annual Meeting

Thomas R. Reardon, M.D., a general practitioner from Portland, Ore., who becomes president of the AMA in June, will deliver a keynote address on Saturday, August 28 at the start of the Second Session of the House of Delegates during the WVSMA's Annual Meeting at The Greenbrier in White Sulphur Springs.

A member of the AMA Board of Trustees since 1990, Dr. Reardon served on its Executive Committee since 1994, as secretary-treasurer from 1994-95, as vice chair of the board from December 1995 to June 1997, and as chair of the board of trustees from June 1997-98. Prior to being named president-elect last June, Dr. Reardon represented the Hospital Medical Staff Section in the AMA House of Delegates from 1983-90.



Reardon

Dr. Reardon began his activities in medical politics with Multnomah County Medical Society (MCMS) and Oregon Medical Association (OMA), serving as president of MCMS from 1980-81 and as president of OMA from 1983-84. In 1986, Dr. Reardon was nominated by the AMA to serve on the Congressional Physician Payment Review Commission (PPRC). He served on the PPRC for eight years and then became an AMA Commissioner to JCAHO prior to being nominated and elected to the National Committee for Quality Assurance Board of Directors in October 1994, on which he currently serves.

Dr. Reardon was recently appointment to the Vice President's Quality Forum Planning Committee.

For more details about this year's WVSMA Annual Meeting, please turn to pages 86-87, or phone the WVSMA at (304) 925-0342.

Drs. Helsley, DeBord named to Publication Committee

James D. Helsley, M.D., an associate professor and medical director of the Visiting Clinician Program at West Virginia University in Morgantown, and Jeffrey B. DeBord, D.O., an internal medicine specialist who practices in Martinsburg and is a clinical assistant professor of medicine at the West Virginia School of Osteopathic Medicine, have been elected associate editors for the WVSMA's Publication Committee.

As associate editors, Drs. Helsley and DeBord with work with Dr. Stephen D. Ward, editor of the *West Virginia Medical Journal*, and the *Journal's* six other associate editors to review and edit articles submitted for publication. The members of the Publication Committee determine the *Journal's* general content and format, and contribute editorials.

Dr. Helsley served as president of the WVSMA from 1995-96, and is currently junior counselor-at-large, as well as an AMA delegate and chairman of the WVSMA's Committee Medical Education. He is a past president of both the Eastern Panhandle Medical Society and the Monongalia County Medical Society.

Dr. Helsley received his medical degree from the West Virginia University School of Medicine in 1977. He interned and completed his residency in family practice at the Medical College of Virginia, and then went into private practice in his hometown of Berkeley Springs.

While practicing in Berkeley Springs, Dr. Helsley began teaching as a clinical assistant professor at Georgetown University Hospital in Washington, D.C., and also at WVU. He is now affiliated on a full-time basis with WVU as an associate professor as well as director of the visiting clinician program. In 1992, Dr. Helsley was named Outstanding Teacher of the Year by the Department of Family Medicine.

A fellow of the American Academy of Family Physicians, Dr. Helsley is a diplomate of the National Board of Medical Examiners and the American Board of Family Physicians.

Dr. DeBord was born in South Charleston and received a bachelor of arts in biology degree from West Virginia University in 1982 and then completed graduate work in cancer research at the WVU College of Graduate Studies. He attended the West Virginia School of Osteopathic Medicine, where he received his D.O. degree in 1987.

After completing a rotating osteopathic internship at Ohio Valley Medical Center and a residency in internal medicine at the Medical College of Pennsylvania, Dr. DeBord began practicing internal medicine in Martinsburg in 1991.

A clinical assistant professor of medicine at the West Virginia School of Osteopathic Medicine, Dr. DeBord is director of medical education for City Hospital in Martinsburg. In addition, Dr. DeBord is currently chairman of the board of directors for Eastern Panhandle Integrated Delivery System and co-chairman of the board of directors for the Eastern Panhandle Health Alliance PHO. He also serves as director of the Panhandle Claims Administrators Board of Directors.

Dr. DeBord is a diplomate of the National Board of Osteopathic Medical Examiners and the American Board of Internal Medicine. In addition to being a member of the WVSMA, Dr. DeBord is a member of the American College of Physicians, the American College of Physician Executives, the American Society of Internal Medicine, the American Osteopathic Association, the AMA, the West Virginia Society of Osteopathic Medicine and the Eastern Panhandle Medical Society, for which he recently served as vice president.

Medical Assurance wins new trial for physician by proving plaintiff fraud

The philosophy of Medical Assurance, the WVSMA's endorsed carrier, has always been to remain vigilant — with an unending commitment to defend.

This commitment was recently illustrated when it defended a physician against a plaintiff who complained his vasectomy left him totally disabled and ridden with pain. This plaintiff won a $2.1 million verdict, despite the fact that no cause for the plaintiff's pain could be found and expert testimony was produced supporting the defendant physician!

However, the physician had repeatedly heard that the plaintiff's claims were false, so Medical Assurance hired a private detective to investigate the reports and rumors. Imagine the surprise when investigators found the plaintiff engaging in activities he testified in court that he was unable to do!

Armed with this evidence, Medical Assurance's motion for a new trial was granted.

WVAAFP plans 47th Scientific Assembly

The West Virginia Academy of Family Physicians will conduct its 47th Annual Scientific Assembly from April 23-25 in Charleston at the Charleston House Holiday Inn.

This meeting has been approved for 21.75 AAFP prescribed credits and a wide variety of scientific sessions, as well as business events, social activities and exhibits have been scheduled.

To register or obtain more information, please contact the WVAAFP at (304) 776-7610.

Phase II of WV CHIP underway

In March, the WV Healthy Kids Coalition and the WV Children's Health Insurance Program will be launching an intensive outreach campaign to enroll children in the WV Children's Health Insurance Program (WVCHIP). At press time, the state's application for Phase II of CHIP was in the final phases for approval by the federal Health Care Finance Administration (HCFA).

As a result of WVCHIP, West Virginia is able to offer health insurance to every uninsured child whose family income is less than 150% of the federal poverty level. Thousands of children are projected to be eligible through either WVCHIP or Medicaid.

While Phase I (children 1-5) expanded, the WV Medicaid Program, Phase II (children 6-18), will be administered by PEIA. An informative newsletter for providers should be mailed soon so physicians and their office staffs will be familiar with the program before patients begin presenting their new insurance cards.

Some of the benefits to be covered under WV CHIP Phase II Benefit Plan include:

* primary care physician visits
* specialty physician visits
* physician visits for diagnostic testing
* well child care as defined by the American Academy of Pediatrics (AAP) guidelines
* immunizations based on the schedule approved by the Advisory Committee on Immunization Practices, the AAP, and the American Academy of Family Physicians
* periodic physical - follow the AAP guidelines (may be included within well child care visits)
* outpatient surgery
* emergency outpatient services and supplies
* urgent care and after hours clinic visits
* speech therapy
* vision therapy - corrective eye exercises for children
* vision services

Physicians can have applications to distribute to their patients by calling 1-888-983-2645 (WVFAMILY). The application is also available on the internet at:
www.wvdhr.org/pages/wvchip

Spangler named Carelink medical director

WVSMA Treasurer Dr. Elizabeth Spangler is the new medical director for Carelink Health Plans in Charleston. She has replaced Dr. Glenn Crotty, who is now chief medical officer for the Camcare Health System.

Dr. Spangler, a board certified specialist in internal medicine, served most recently as vice president for clinical affairs and medical director of Home Health Services. A graduate of the Marshall University School of Medicine, she joined the medical staff at Charleston Area Medical Center in 1990.

In addition to being treasurer for the WVSMA, Dr. Spangler is vice president of the Kanawha Medical Society.

Dr. Crotty and Robert L. Savage, president and CEO of CAMC, noted in a joint letter to the hospital's medical staff that Dr. Spangler "has been instrumental in the system's quality and and performance improvement activities, and has worked hard to support the medical staff as well as the system. This will make our entire system stronger and more responsive to your needs, as well as to the needs of your patients and the community."

Nominations wanted for Country Doctor of the Year

Know a great country doctor who still provides old fashioned care to lifelong patients?

Staff Care, Inc., a Dallas-based temporary physician staffing firm has put out a call for nominations for its 1999 Country Doctor of the Year Award. This national award, now in its fifth year, is presented to a physician who best exemplifies the spirit, skill and dedication of America's rural medical practitioners.

The recipient of the award will receive a personalized bronze plaque depicting the award's signature logo — a country doctor making his rounds in a horse and buggy, as well as an interim physician for one week at no cost so the doctor can take some time off.

For a nomination form, call Staff Care at (800) 685-2272. Forms must be returned by April 10.

Spring meeting for ophthalmologists set for April 22-25

The West Virginia Academy of Ophthalmology's 51st Annual National Spring Meeting will take place at The Greenbrier in White Sulphur Springs from April 22-25.

Featured speakers will include Philip A. Shelton, M.D., J.D.; M. Bruce Shields, M.D.; Richard L. Lindstrom, M.D.; and Walter J. Stark, M.D. Topics to be discussed include medical/legal issues, malpractice, managed care, glaucoma, cataracts and refractive surgery.

This meeting has been designated by the WV Academy of Ophthalmology for 15 credit hours in Category 1 of the PRA of the AMA.

For further details, contact the WV Academy of Ophthalmology at P.O. Box 5008, Charleston, WV 25361; phone (304) 343-5842.

Medical Meetings

April

17-20 - American Academy of Pediatrics, Chicago

18-21 - American Association for Thoracic Surgery, New Orleans

22-25 - American College of Physicians, New Orleans

23-30 - 58th Annual American Occupational Health Conference, New Orleans

29-May 2 - National Kidney Foundation's 8th Annual Clinical Nephrology Meetings, Washington, D.C.

May

1-6 - Toward an Electronic Patient Record, Orlando

2-7 - American Society of Colon and Rectal Surgeons, Washington, D.C.

10-12 - International Symposium on Cosmetic Efficacy, New York, N.Y.

14 - Setting a New Standard of Care: An Office-Based Management Program for Hyperlipidemia in a Managed Care Setting, Arlington, Va.

15-19 - American College of Obstetricians and Gynecologists Annual Clinical Meeting, Philadelphia

18-19 - American Association of Women Emergency Physicians, Boston

22-27 - 37th American American Society of Neuroradiology Meeting, San Diego

June

2-4 - Aggressive Management of Cardiovascular Emergencies: Including Urgent Echocardiography, Controversies, Case Discussions, and Recent Advances, Bethesda, Md.

8-11 - Interhospital/Interfab 99, Hannover, Germany

9-12 - Primary Care Ortopaedics Course, Chicago

E-file your tax return now. Wait to pay till April 15

Even if you owe more tax, you can file your return early with IRS *e-file*—get quick proof that your return is accepted—but wait until April 15th to pay.

IRS *e-file* is simple and secure. And so accurate, there's less chance you'll get a letter from the IRS.

You have convenient payment options when you e-file. One option allows you to authorize a withdrawal from your bank account on the date you choose, up to April 15th. Another option allows you to pay with your credit card.

If you expect a refund, all the better. This way, you can get it back in half the usual time. Even faster with Direct Deposit.

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Watch for topics and speakers for this year's Annual Meeting in future issues of the *West Virginia Medical Journal* and other WVSMA publications.

The West Virginia State Medical Association

132nd Annual Meeting

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- Scientific Sessions
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- Exhibits
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Registration Form

Name _____

Address _____

City/State/Zip _____

Phone _____ **Fax** _____

Specialty _____

Please detach and mail with payment to:
WVSMA, P.O. Box 4106, Charleston, WV 25364.

Would you like to register over the phone? Just call us at (304) 925-0342. Please have your Visa or MasterCard ready.

Fax us your registration form at (304) 925-0345.

Request an e-mail registration form! Visit our website at www.wvsma.com. Complete our Guestbook and request a registration form!

Registration Fees — Before August 1, 1999 (Early Bird)

❒ WVSMA Member	$115
❒ Non-member	$165

Registration Fees — After August 1, 1999

❒ WVSMA Member	$125
❒ Non-member	$175

Lunch & Learn — Thursday, August 26, 1999
"Evaluation & Management Guidelines for Fraud and Abuse"

❒ WVSMA Member	$50 (each session)
❒ All others	$35 (each session)

Lunch & Learn — Friday, August 27, 1999
"Impacting the Legislative Process"

❒ WVSMA Member	$50 (each session)
❒ All others	$35 (each session)

Total Due: _____

Payment by: ❒ Check ❒ MasterCard ❒ VISA

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Expiration Date _____

Signature _____

Cancellation of registration should be in writing. If a cancellation is postmarked or phoned to the WVSMA before August 1, 1999, the paid registration fee will be refunded less a $50 administrative charge. For cancellations after August 1, 1999, no refunds will be made.

CME & Special Events

Camcare Health Education & Research Institute

"Common Foot Problems"
April 5, 12:30 p.m., Scott Glassburn, D.P.M., Montgomery General Hospital, Montgomery

"Tumor Conference: Prostrate Cancer"
(Guest lecture) Daniel Petrylk, M.D., April 12, noon, Robert C. Byrd HSC of WVU, Charleston Division

"Treatment of Depression"
April 20, 5:45 p.m., Mark Casdorph, D.O., Tamarack, Beckley

"Cardiology Conference: Coronary Artery Risk Detection in Appalachian Communities"
(Guest lecture) April 21, 8 a.m., William Neal, M.D., Robert C. Byrd HSC of WVU, Charleston Division

"Black Lung Evaluation"
April 21, 6 p.m., James Walker, M.D., Man Appalachian Regional Hospital, Man

"OB/GYN Update: A Pre-Conference for the Family Physician
April 22, 5 p.m. - 9 p.m., E. Reed Heywood, M.D., Charleston House Holiday Inn, Charleston

"26th Annual Newborn Day: Hematology Disorders of the Newborn"
April 23, 7:30 a.m., Stefan Maxwell, M.D., Tamarack, Beckley

"Geriatric Trauma"
April 26, 5:45 p.m., Frank C. Lucente, M.D., Cafe Acropolis, Summersville

Huntington Community Medical Foundation

"Colon Cancer: Prevention and Detection - What Do Recent Advances in Genetics Teach Us"
April 14, 6 p.m., Charles Turner, M.D., (George Cortas, M.D., will also speak), Brass Tree Restaurant, Williamson

"Special Outreach Conference"
April 17, 8:15 a.m. - noon, Brass Tree Restaurant, Williamson

"Breast Cancer: Risk, Assessment and Prevention,"
James Morgan, M.D.
"Recognizing Lung Cancer in the Physician's Office"
Victor Ferraris, M.D., Ph.D.

"Ethics of Giving/Withholding Tube Feedings"
April 19, 6 p.m., Shirley M. Neitch, M.D., Three Rivers Medical Center, Louisa, Ky.

"Fungal Infections"
April 22, noon, Timothy G. Saxe, M.D., Pleasant Valley Hospital, Point Pleasant

"Medical Malpractice - Reducing Risk"
April 26, Kathi L. Burton, Medical Assurance of WV, Inc. Logan General Hospital, Logan

"Chronic Pain Management"
April 27, 6 p.m., Feliz Munoz, M.D., Paul B. Hall Regional Med. Center, Paintsville, Ky.

"Sports Medicine: Management of Concussion"
April 29, noon, Ross M. Patton, M.D., Pleasant Valley Hospital, Point Pleasant

Marshall University School of Medicine

"Myocardial Perfusion Imaging in Emergency Room Chest Pain Patients"
April 6, 8 a.m., James Udelson, M.D., Cabell Huntington Hospital, Huntington

"WVAAFP 47th Scientific Assembly"
April 23-25, Charleston House Holiday Inn, Charleston

"Together for Special Kids: Exploring the Fine Art of Parent Professional Collaboration"
May 22, MU Medical Center

Robert C. Byrd HSC - Morgantown

"Malignant Pleural Effusion"
April 6, 7:30 p.m., Geoffrey Graeber, M.D., Fairmont General Hospital, Fairmont

"Fall Prevention"
April 8, 1 p.m., Shirley Kimble, E.M.T. - P, Broaddus Hospital, Phillipi

"Fourteenth Medicolegal Investigation of Death Seminar"
April 10, Robert C. Byrd HSC of WVU, Morgantown

"Spasticity"
April 21, 1 p.m., Atiya Kahn, M.D., Fairmont Clinic, Fairmont

"Fourteenth Medicolegal Investigation of Death Seminar"
April 10, Robert C. Byrd HSC, Morgantown

West Virginia State Medical Association

WVSMA's Annual Meeting
Aug. 25-28, The Greenbrier, White Sulphur Springs

A Dermatologist's Advice to Mad Dogs and Englishmen

Only mad dogs and Englishmen, it has been said
Go out in the noonday sun and get red.

So never let it be said that you are one
To expose yourself to the midday sun.

Though there's clouds or fog or smog or haze
There still comes through ultraviolet rays.

On a cloudy day, when the sun is gone
You should still go out with your sunscreen on.

If your sunscreen use is "by the book,"
Your skin will maintain its youthful look.

Sun bathing should fill your heart with loathing.
In the sun you should not take off your clothing.

What of suntan parlors? Here's the answer:
Why spend money to buy skin cancer?

Bask in the sun and you may become famous
For skin cancers, both basal cell and squamous.

And not only does sun cause carcinomas,
It increases your risk for melanomas.

So swim, play tennis, play golf, have fun,
But preferably not in the midday sun.

Neither tan nor red, your skin will be white,
But much to your dermatologist's delight.

Harold L. Saferstein, M.D.

Increasing tobacco taxes: It's a *health* issue

Death and disease are in the news daily, but what kind of numbers does it take to get the attention of the reader? What about *over 4,200 West Virginians dying each year* from something that is totally preventable -- cigarette smoking, the number one preventable cause of death in the U.S. and in West Virginia?

The Health Statistics Center of the WV Bureau for Public Health has released a report, *"Tobacco Is Killing (and Costing) Us,"* that details smoking-attributable mortality and morbidity economic costs for the state. County-specific details are presented for smoking-related direct health care costs, and the report includes data on smokeless tobacco use rates for adults and youth.

If we combine the number of deaths from AIDS, alcohol, car accidents, fires, cocaine, heroin and suicides, that total is still outweighed by the number of deaths just from smoking. So why the apathy among lawmakers and even health professionals in addressing this epidemic? It could be that we blame the smoker for engaging in a habit that is known to be lethal, but when did that smoker get hooked? They probably got hooked before they turned 18, like 85% of all adult smokers.

The age at which youth begin smoking seems to be getting younger every year, according to Dr. Henry G. Taylor, commissioner for the Bureau for Public Health. "About 8% of our kids reported that they had smoked a whole cigarette by the time they were eight years old. Over half of our kids had done so by the time they were 12 years old," said Dr. Taylor. "Over one-fourth of adults in West Virginia smoke. More alarmingly, 42% of our teenagers are current smokers (U.S. rate 36%)," he added.

Rates for smokeless tobacco use among males in West Virginia are among the highest in the nation. The state's 1997 rate of 17% among adult males was over twice the national average, and smokeless tobacco use by males ages 15-19 was 31% (national average 16%). Anecdotal reports from health professionals say that toddlers as young as three years old are given spit tobacco in West Virginia.

"As the public health officer for the state, it is my responsibility to inform my fellow West Virginians that cigarette smoking kills 4,261 West Virginians each year and costs West Virginia over $656 million per year in direct health care costs," said Dr. Taylor. "We will continue to experience these enormous costs in lives and dollars unless we fund and implement a comprehensive plan for tobacco use prevention and control. In this case, as in all preventable diseases, an ounce of prevention is worth a pound of cure."

Daniel Foster, M.D., chair of the Coalition for a Tobacco-Free WV, states, "Our membership includes over 150 organizations and public and private sector representatives, and is instrumental in researching and disseminating information concerning these issues of tobacco prevention and control. We encourage you to join us in our efforts to turn this epidemic around."

The comprehensive plan for tobacco control that Dr. Taylor mentioned must begin by addressing how to decrease youth consumption of tobacco. **The single, most effective measure that we can implement to reduce these rates by youth is to increase the excise taxes on these products, which raises the price.** Youth are extremely sensitive to price increases, as detailed in a tax study published by the Bureau last year. If we raised the cigarette excise tax by 50 cents, we would see over 38,000 kids ages 12-17 stop smoking or never begin. Of that group, 4,953 lives would be saved from premature deaths as adults.

At 17 cents a pack, West Virginia's cigarette tax is among the lowest in the nation (national average 37.4 cents). It has not been raised since 1978, but in this 20-year period other states have raised their taxes over 150 times! We are one of the eight states that do not tax products other than cigarettes. Governor Underwood's proposed tax on "smokeless tobacco" would actually tax everything but cigarettes at 25% of wholesale cost. By imposing this tax, we should see a decrease in spit tobacco use at a rate of 11.1% or between 2,118 to 2,876 boys quitting snuff in grades 9-12. It is very likely that the low price of spit tobacco products has contributed to the higher rates of use among youth because they erroneously view these products as cheaper and less dangerous than cigarettes.

The Health Statistics Center has also released the 1998 Results of Synar Monitoring, inspections of tobacco retailers for illegal sales to youth. This report indicates that there has been no improvement in illegal sales since 1997, maintaining the average rate of illegal sales at 25%. To enforce the federal regulations, the Bureau is partnering with FDA to implement the enforcement program, with penalties to retailers as high as $10,000.

For more information, please phone the WV Bureau for Public Health, Tobacco Control Program, (304) 558-0644.

Kathi Elkins, M.B.A.
Program Manager
Tobacco Control Program/ASSIST
Bureau for Public Health

The tobacco industry believes life is cheap.

That's why the price of cigarettes shouldn't be.

A lifetime of tobacco addiction typically begins before a kid turns 19. One out of three kids who smokes will die prematurely of smoking-related causes.

Will this be your kid?

For every 10% increase in the price of cigarettes, usage among youth decreases 14%.

If these numbers are alarming to you, here's a number that can help caring parents and adults combat the tobacco industry.

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Coalition For A Tobacco-Free West Virginia

Robert C. Byrd Health Sciences Center of West Virginia University News

Voice specialist joins WVU faculty

Laryngologist Dr. James D. Garnett, who was previously in private practice in Palm Beach, Fla., has joined the WVU faculty.

A board-certified otolaryngologist, Dr. Garnett specializes in the diagnosis and treatment of tumors, polyps or nodules in the larynx, neurological problems such as tremor and paralysis of the vocal cords, and functional problems. Voice problems can be treated with speech therapy, medication, or surgery. Dr. Garnett works with a team of WVU specialists, including speech and language pathologists, neurologists, pulmonologists and audiologists, to determine the correct treatment and followup care for each person.

Dr. Garnett is a graduate of the University of Virginia School of Medicine, who completed postgraduate training at WVU and Vanderbilt University.

Cancer patients may benefit from new drug

An experimental drug tested at WVU's Mary Babb Randolph Cancer may increase the number of people who can benefit from stem cell transplantation, which is used to help patients with cancer and other serious diseases survive the side effects of chemotherapy.

WVU's Blood and Marrow Transplant Program is one of 10 centers in the U.S. which tests recombinant human thrombopoietin (rhTPO), a synthetic form of a naturally occurring substance in bone marrow. This substance is part of the body's mechanism for producing platelet cells.

Gangarosa named to two AGA committees

Gangarosa

Dr. Lisa Gangarosa of the WVU School of Medicine Dept. of Gastroenterology has recently been appointed to two committees of the American Gastroenterological Association.

Dr. Gangarosa will serve on the group's Committee on Clinical Practice and Practice Economics, which reviews the standards of care. She has also been named to the Trainee Committee, for those with less than five years experience in the field.

"This is all very new to me," said Dr. Gangarosa, "But I am looking forward to meeting people across the country, and especially pioneers in the field of gastroenterology."

WVU Eye Center offers new procedures

Two new outpatient excimer laser procedures are now available at the West Virginia University Eye Center – Laser In-situ Keratomileusis (LASIK), and Myopic Astigmatic Photorefractive Keratectomy, also known as Toric PRK.

LASIK, currently considered an "off label" use of the excimer laser, is indicated for severe myopia. Toric PRK is an alternative procedure for high myopes with or without astigmatism.

LASIK melds an established surgical technique, Lamellar Kertoplasty (LK), with the newer laser method, Photorefractive Keratectomy (PRK). The surgeon uses a microkeratome to cut and fold back a thin, hinged flap of the cornea. The protective flap is retracted and the excimer laser is then used to shape the cornea beneath.

In Toric PRK, the surgeon places a custom-made ablatable disk or mask in the path of the laser beam. By allowing the laser beam to cut through the thinner areas of the mask first, the disk transfers the pattern onto the patient's cornea. Each ablatable disk is precision-made to fit the requirements of the individual patient.

Surgical services for neonates, pediatric patients expanded

With the addition of Dr. Peter Ehrlich to the faculty, WVU Children's Hospital is able to offer expanded surgical services for neonates and pediatric patients.

Dr. Ehrlich, a board certified pediatric surgeon, offers diagnostic, consultative, and treatment services for children, including congenital diseases of the lung and gastrointestinal tract. He has a special interest in pediatric oncology and is a member of the Society of Pediatric Oncologists. In addition, he has expertise in minimally invasive surgery and anorectal malformations.

When appropriate, outpatient surgery is performed in Children's Hospital or Ruby Day Surgery Center with support from the pediatric specialty team and pediatric anesthesiology.

West Virginia Chapter — American College of Surgeons

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"Hernia Repair Year 2000"
Ira Rutkow, M.D., F.A.C.S., *Clinical Professor, Central State Medical Center and the Hernia Center, Freehold, NJ*

"Education of a Surgeon"
Olga Jonasson, M.D., F.A.C.S., *Director Education and Surgical Service Department, American College of Surgeons*

Speakers from the Southwestern Pennsylvania Chapter, the West Virginia Chapter and residents from WV training programs will complete the program. A golf tournament and reception will be Friday. There will be a $100 registration fee and 11.5 CME hours are available. For more information, contact Sharon Bartholomew at (304) 598-2802. For room reservations, contact The Greenbrier at (800) 624-6070.

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*Dietary Approaches to Stopping Hypertension Trial
Appel, LJ et al., NEJM, 336 (16), 117-24, 1997

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Marshall University School of Medicine News

Marshall assistant dean, medical student win rural health honors

Marshall medical students Lynn Amores, Thomas Rittinger and Patrick Stone stand ready to answer lawmakers' questions during Rural Health Education Partnership Day at the West Virginia Legislature.

Patrick Stone, a fourth-year medical student from Poca, and Michael J. McCarthy, assistant dean for information technology and medical informatics at the Marshall University School of Medicine, were honored for their rural health contributions by the West Virginia Rural Health Education Partnership on February 22 in Charleston.

Stone received the Outstanding Student Research Project award for a project in which he used a questionnaire to detect peripheral vascular disease, a group of conditions that result in reduced blood supply to the leg and arm muscles. He did the study while assigned to the Cabin Creek Health Center for six months.

Stone said he decided to do the study after seeing that a large number of patients had risk factors for vascular disease. "It's also an awareness issue," he said. "We need to ensure that patients are aware that tobacco can and does affect vascular disease. We as physicians have to let our patients know that smoking affects more than just lungs."

McCarthy was honored as the 1999 recipient of the Judith C. Kandzari Award, given for "outstanding and exemplary contribution on the part of a campus-based faculty member who goes beyond the expectation and traditional role of outreach service to rural communities in guiding the training of students."

McCarthy developed a World Wide Web-based scheduling program that helps health professions students, who are required to complete at least three months of rural clinical experience, view information on training opportunities in rural locations and select their rotation sites. He also developed electronic mail discussion lists and worked with rural teaching sites to create web sites for each regional consortium and the Rural Health Education Partnership itself.

The partnership is a program for educating health sciences students in rural communities, and is designed to introduce students to the rewards and challenges of rural practice. More than 450 rural health care professionals serving the most underserved areas of 47 counties act as field faculty.

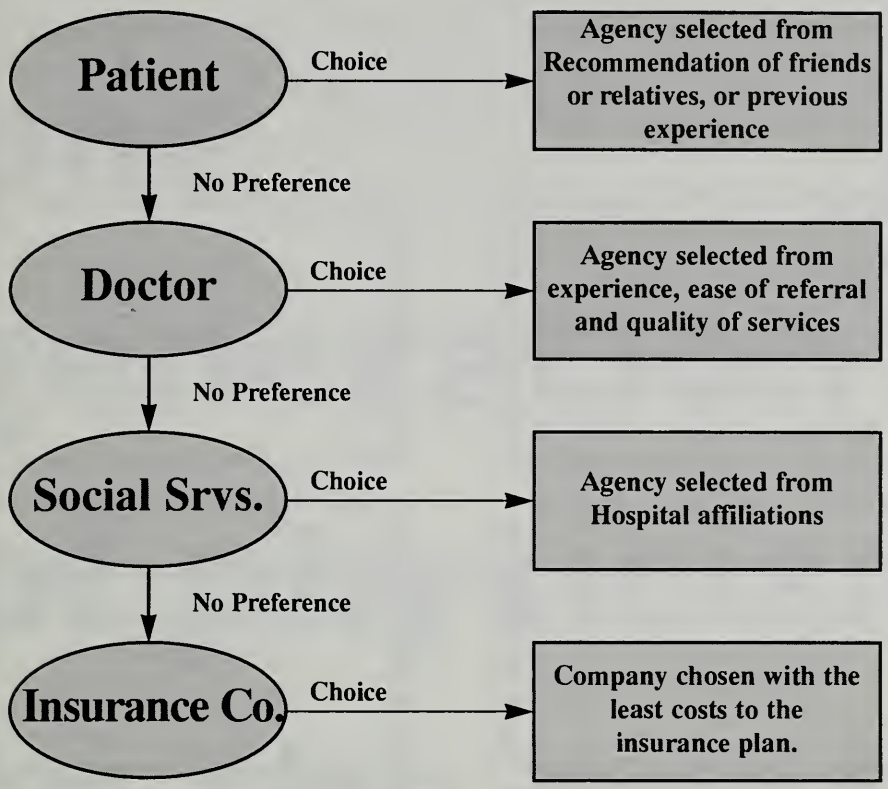
Huntington Clinical Foundation funding pilot computer project

The Huntington Clinical Foundation is funding a pilot program which will provide up to 10 hand-held computers loaded with medical reference software for use by medical students, according to Michael J. McCarthy, assistant dean for information technology and medical informatics.

The project probably will use 3Com Palm III computers with software such as Griffith's: 5 Minute Clinical Consult and drug databases. "We would like to study the utility of these devices as a bedside reference for medical students in a clinical setting," McCarthy said.

"We want to see if we can streamline students' access to the common reference texts that they otherwise would have to carry," McCarthy explained, noting that students typically use four or five one-pound-plus reference texts when they are seeing patients. "The computers will give students the added advantage of being able to query the entire contents of the device on a word or phrase."

Healthcare — Who's Choice is it?



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The WVSMA Alliance salutes its West Virginia physicians! These "ads" have been purchased by Alliance members as a way to honor physicians throughout the state. Proceeds will go to benefit the AMA Foundation.

To my Daddy,
Ed Mandac
Love, Michael

Happy Doctors' Day!
Dr. Brandt Williamson
Love, Martha, Ellerie, and Hastings

Adel E. Frenn
To our Daddy
We Love You,
Andreah and Justin

Ohio County Physicians
We're Proud of You!
Happy Doctors' Day,
Your Alliance

Jim Comerci
Happy Doctors' Day!
Love,
Your Family

Physicians of Family Medical Associates, Inc.
Happy Doctors' Day!
From your Super Staff!!

Dr. Rick Latos
Happy Doctors' Day!
With love,
Michelle and Mike

Dr. Derrick Latos
Thanks for all you do,
especially at the
Transplant Games,
Fondly, Your Team!

Happy Doctors' Day!
Dr. Michael Fortunato
With love,
Kathy, Joe, Andrea
Nick and Christina

Dr. Bob
Happy Doctors' Day!
Love,
Elaine, Anne and Dawn

To the Best Doctor,
Husband & Daddy
Happy Doctors' Day!
Dr. Philip C. VanDongen
Hugs & Kisses,
Ginny, Matthew and Kimberly

Happy Doctors' Day!
Dr. Joe S. Romero
From the "ladies" in your life
(your loving wife & 3 daughters!!)

Happy Doctors' Day!
Dr. Jonathan Lechner
From:
Joyce, Justine, Josh and Your Staff!

Happy Doctors' Day!
Dr. Rajai Khoury
From:
Your Family

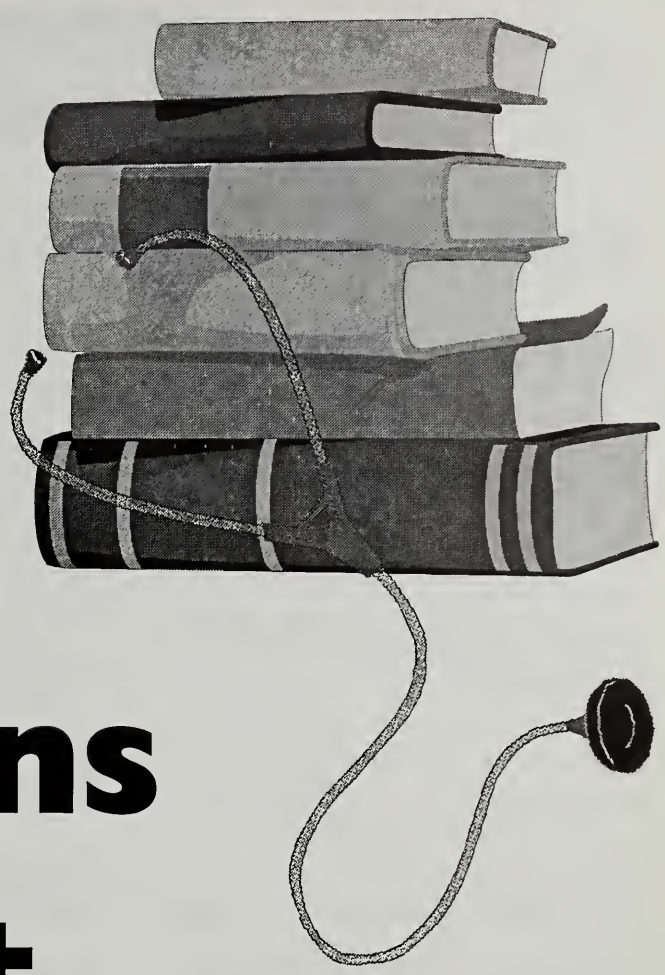
Dr. Thomas Wack
Thank you for caring
for our health!
Dr. Terry, Linda, Becca, and Ashley Elliott

Happy Doctors' Day!
Dr. John Holloway
You're the best!!
Love, Sherry, Dan & Jess

Dr. Terry Elliott
Thank you for being the person we love. You're an excellent doctor, too!
Your Family - Linda, Becca & Ashley

Dr. Harvey Reisenweber
Happy Doctors' Day
Love,
Your Family

From one generation of physicians to the next.



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- **Or, the Medical Student Assistance Fund, which is used specifically for student scholarships.**
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- **Mail checks to Michelle Latos, 2 Augustwood, Wheeling, WV 26003. For information about AMA Foundation, call (304) 233-7480**

New Members

We are pleased to welcome the following new members to the WVSMA:

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Keith M. Zora, MD
Weirton, WV

Robert F. Dundervill, III, MD
Charleston, WV

Robert W. Azar, MD
Vienna, WV

Sharon T. Kapeluk, MD
Lewisburg, WV

Symon Satow, MD
Hinton, WV

Lucas Pavlovich, MD
Elkins, WV

Rajendra G. Joshi, MD
Keyser, WV

Mark N. Casdorph, DO
Charleston, WV

Sherry L. Apple, MD
Charleston, WV

Paul S. Lee, MD
Huntington, WV

Hong I. Seung, MD
Wheeling, WV

Peeng J. Isai, MD
Fairmont, WV

Troy D. Foster, DO
Martinsburg, WV

Rose Wong, MD
Wheeling, WV

Todd E. Tallman, MD
Wheeling, WV

Mario Matos Cruz, MD
Wheeling, WV

Nabeel G. El-Amir, MD
Wheeling, WV

Ramsey Behnam, MD
Lewisburg, WV

Steven A. Lovejoy, MD
Huntington, WV

Luis Bolano, MD
Huntington, WV

David Nicholas, MD
Huntington, WV

Bradley Nine, MD
Huntington, WV

Jerry W. Scott, MD
Cross Lanes, WV

Mohammad A. Ullah, MD
Prosperity, WV

Glen D. McKnight, Jr., MD
Ripley, WV

Residents

Hassan Alhosaini, MD
Wheeling, WV

Lisa C. Hill, MD
Wheeling, WV

Elizabeth Hess, MD
Wheeling, WV

Chester Austin, MD
Wheeling, WV

Eunice L. Leaf, MD
Wheeling, WV

Kelly R. Leaf, MD
Wheeling, WV

Nida E. Nicasio, MD
Wheeling, WV

Craig D. Schmalzreid, MD
Wheeling, WV

Diane S. Swensen Miller, MD
Wheeling, WV

Stephanie L. Frame, DO
Elkins, WV

Rajiv Jain, DO
Stonewood, WV

Mark Henson, MD
Bridgeport, WV

Robert P. Romano, MD
Clarksburg, WV

Medical Students

WVU School of Medicine (Morgantown)

Dan Elswick
Richard L. Smith, II
Kevin Eggleston

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- Latest happenings at the WVSMA;
- Legislative news;
- Sign our guestbook and let us know you stopped by;
- Information about upcoming meetings and events;
- Other important information you don't want to miss!

WWW.WVSMA.COM

WESPAC News

We would like to thank the following individuals for their recent contributions to the 1999 WESPAC Fund:

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Obituaries

Robert William Hibbard, M.D.

Dr. Robert William Hibbard, 75, of Huntington died Jan. 20, in the Wayne Continuous Care Center.

Dr. Hibbard was born in Huntington and attended Marshall University. He completed his premedical studies at the University of Louisville and received his medical degree from the University of Tennessee. He interned at Charleston General Hospital and completed his residency in psychiatry at the University of Indiana Medical Center in Indianapolis.

Dr. Hibbard served in the U.S. Navy during both World War II and the Korean War. In 1954, he started his private practice in Huntington. He was a board certified psychiatrist and a life fellow in the American Psychiatric Association. In addition, Dr. Hibbard was a charter member and past president of the West Virginia Psychiatric Association, as well as one of the founders of the St. Mary's Psychiatric Department and chief of that department for 14 years.

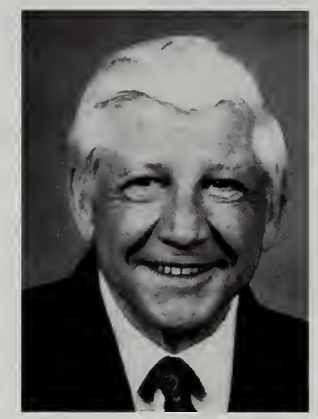
A former vice president of the Cabell County Medical Society, Dr. Hibbard's academic appointments included clinical professor of psychiatry at the West Virginia University School of Medicine, Marshall University School of Medicine and the University of Kentucky School of Medicine. During his career, he also served as a psychiatric consultant to the Logan Mingo Mental Health Center; the Atomic Energy Commission, Portsmouth, Ohio, Division; and the Huntington State Hospital. In addition, he founded the Huntington Institute of Rational Thinking and produced a cartoon movie on rational thinking.

Dr. Hibbard was preceded in death by two half brothers, Albert and Thomas Hibbard.

Survivors include his wife, Velma Blake Hibbard; and four children, Karen Hibbard Ableleda of Ft. Lauderdale, Fla., Susan Hibbard Michaud of Madawska, Maine, Greg Hibbard of West Palm Beach, Fla., and Robert F. Hibbard of Huntington; and four grandchildren, Bradley Hibbard, and Joshua, Abigail and Rebekah Michaud.

Contributions can be made to the Alzheimer's Association, Southern WV Chapter, 400 Allen Drive, Suite 20, Charleston, WV 25302 or The American Parkinson Disease Association, 1250 Hylan Blvd., Suite 4B, State Island, KY 10305-1946.

John Jefferson Mahood, M.D.



Dr. John Jefferson Mahood of Bluefield, a past president of the WVSMA and the Mercer County Medical Society, died Jan. 6, from complications of diabetes.

Dr. Mahood grew up in Bluefield and graduated from the University of Virginia with a bachelor's degree in 1943. He taught trigonometry and calculus at Pocahontas High School before entering the University of Virginia Medical School, where he received his M.D. degree in 1947. He interned and completed his residency at Detroit Receiving Hospital and completed post graduate work in dermatology at Wayne University Medical School.

Dr. Mahood returned to Bluefield and practiced dermatology there for 42 years. During his career, Dr. Mahood served as director of the Mercer County Health Department for 11 years and was chairman of the Mercer County Society for Crippled Children and Adults, as well as chairman of the Mercer County Heart Association. A past president of the Mercer County Cancer Society, Dr. Mahood was a member of the state board, and also served for five years on the West Virginia State Board of Medicine.

A WVSMA member since 1953, Dr. Mahood served as president from 1976-77 and was very active on the Council and a number of committees. Prior to being president of the Mercer County Medical Society from 1963-64, he served as its secretary/treasurer. Dr. Mahood was also affiliated with the AMA; the Washington Dermatological Society; World Medical Association United States Committee; American Academy of Dermatology; the Masters Dermatologic Association, the West Virginia Medical Institute; the American College of Physicians of Dermatology; the International Congress of Dermatology; the American Dermatologic Association; and Pu Mu Chapter of Phi Chi Medical Fraternity. He presented papers for the International Congress of Dermatology in Munich in 1965, and had a number of articles published during his career.

A lifetime member of the University of Virginia Alumnae Association, Dr. Mahood was a patriarch member of the Thomas Jefferson Society. He was an active member of the Christ Episcopal Church.

He was preceded in death by a brother, Alex Blount Mahood, Jr.

Survivors include his wife, Norma Dawson Mahood, a columnist for the *Daily Telegraph*; children, Jean Louise Mahood, Julia Elizabeth Mahood and her husband, Rex Macey, all of Atlanta, Ga., Kathleen Page and son, Alex of Colorado; and a sister, Belva Mahood Hicks of Roanoke, Va.

Lee L. Neilan, M.D.

Lee Lowry Neilan, 60, of South Charleston died Feb. 2 at home of cancer.

Dr. Neilan was born in Washington, D.C., and received her medical degree from Georgetown University in 1976. She interned at Providence Hospital in Washington, D.C., and then did her residency in psychiatry at the West Virginia University School of Medicine, Charleston Division.

Dr. Neilan practiced psychiatry in Charleston and was a very active member of the WVSMA and Kanawha Medical Society. Dr. Neilan was a fellow of the American Psychiatric Association and was a member of the AMA. She was an elder of First Presbyterian Church, South Charleston, and a member of the Pilot Club of the Greater Kanawha Valley.

Surviving: husband, George Neilan; sons, Dr. Robert Neilan of Greensboro, N.C., Dr. Edward Neilan of Chestnut Hill, Mass; daughter, Dr. Joyce Neilan of West Chester, Pa.; sisters, Louise Lawrence of Knoxville, Tenn., Carla Lowry of Georgetown, Texas; and one grandchild.

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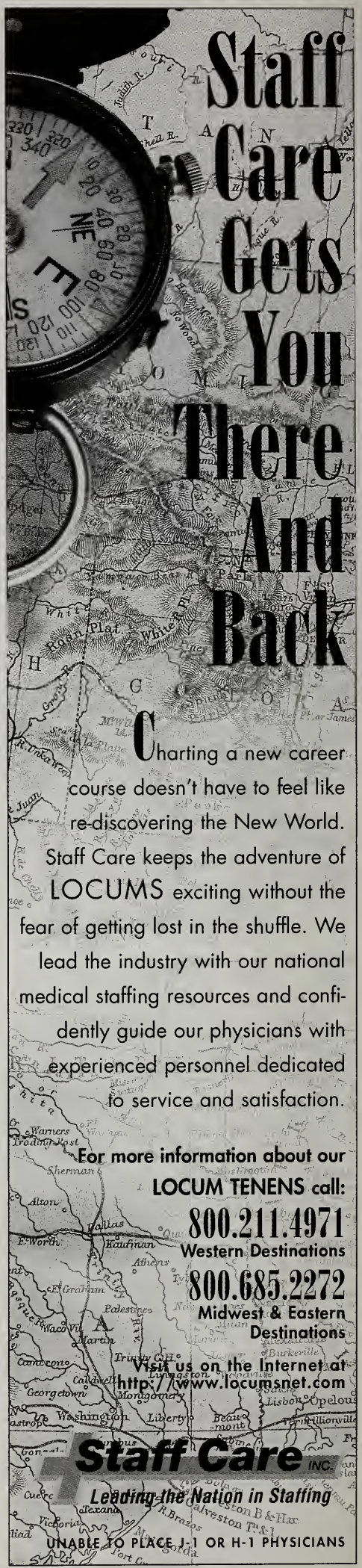

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Seminars

Issues in Medical Ethics
Wednesday, June 9, 1999
8 a.m. – 5 p.m.
Tamarack, Beckley, WV
Robert T. Hall, PhD
Program Chairman

3rd Annual Pediatric Critical Care Conference
Thursday, October 14, 1999
8 a.m. – 3:15 p.m.
Robert C. Byrd Health Sciences Center of WVU/Charleston Division, auditorium
Manuel Caceres, MD
Program Chairman

14th Annual Trauma Conference
Friday, November 5, 1999
8 a.m. – 4 p.m.
Tamarack, Beckley, WV
James W. Kessel, MD
Program Chairman

9th Annual Vascular Surgery Conference
Saturday, October 16, 1999
8 a.m. – noon
Robert C. Byrd Health Sciences Center of WVU/Charleston Division, auditorium
Ali F. AbuRahma, MD
Program Chairman

On-Site Continuing Education Outreach Program

Chronic Pain Management
Wednesday, June 2, 1999
12:30 p.m.
Montgomery General Hospital
Montgomery, WV
Timothy Deer, MD

High Risk Obstetrics and Perinatal Care
Monday, June 7, 1999
5:45 p.m.
Café Acropolis
Summersville, WV
Stefan Maxwell, MD
Wayne Conover, MD

Common Respiratory Problems
Thursday, June 10, 1999
5:45 p.m.
Twin Falls Resort State Park
Mullens, WV
Loay Al-Asadi, MD

Geriatric Trauma
Wednesday, June 16, 1999
6 p.m.
Man ARH
Man, WV
Frank Lucente, MD

Sexual Assault Nurse Examiner Program
Wednesday, July 7, 1999
12:30 p.m.
Montgomery General Hospital
Montgomery, WV
Pat Meadows, RN
Sam Silverstein, RN

Bee Stings and Allergic Reactions
Friday, July 9, 1999
noon
Logan General Hospital
Logan, WV
Nasim Sheikh, MD

Acute Pain Management
Tuesday, July 13, 1999
5:45 p.m.
Tamarack, Beckley, WV
Ray D'Amours, MD

Sexual Assault Nurse Examiner Program
Tuesday, July 20, 1999
6:30 p.m.
Roane General Hospital
Spencer, WV
Pat Meadows, RN
Sam Silverstein, RN

Acute and Chronic Renal Failure
Wednesday, July 21, 1999
6 p.m.
Man ARH
Man, WV
Robert Vaughn Lamb, MD

Diagnosis and Treatment of Congestive Heart Failure
Monday, August 2, 1999
5:45 p.m.
Sycamore Creek Golf Club
Ripley, WV
William Carter, MD

Lacrosse Encephalitis
Wednesday, August 4, 1999
12:30 p.m.
Montgomery General Hospital
Montgomery, WV
James McJunkin, MD

Guest Lectures/Tumor Conference

Prevention of Severe Chemo-therapy Induced Thrombocytopenia
Monday, July 19, 1999
noon
Robert C. Byrd Health Sciences Center of WVU/Charleston Division, room 2000
Randi Isaacs, MD
Hackensack University Medical Center
New Jersey

Phase I Trial: Metastatic Breast Cancer
Monday, September 13, 1999
noon
Robert C. Byrd Health Sciences Center of WVU/Charleston Division, room 2000
Brenda Nicholson, MD
Vanderbilt Medical Center
Nashville, TN

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A rainbow over a farm near Volga in Barbour County.

Photo courtesy of Stephen J. Shaluta, Jr., West Virginia Department of Commerce.

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Manuscript Guidelines

All articles for the *West Virginia Medical Journal* must be submitted on an IBM compatible disc. Wordperfect 5x, Wordperfect 6.0/6.1, Microsoft Word for DOS, and other languages are acceptable. If the manuscript contains tables, the main body of the manuscript and references should be saved as one item, i.e., *article*, and then each table should also be saved as a separate item, i.e., *Table 1, Table 2.*

All scientific manuscripts should be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."* Papers will not be considered for publication if they have already been published or are described in a manuscript submitted or accepted for publication elsewhere. All persons designated as authors should have participated enough in the work to take public responsibility for the concept.

Manuscripts should be accompanied by one extra copy, be double-spaced, have each page numbered and should include a title page, an abstract of no more than 150 words, and references numbered consecutively. No more than 10 references will be published and then a statement will appear that the author should be contacted for the other references listed in the manuscript.

Tables, figures and photos should be numbered, and indicated with parentheses whenever they are mentioned in the text, i.e. (Table 1), (Figure 1). Legends should be included for all figures and photographs.

Photos must be unmounted glossy prints in a 5 x 7 format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author at a cost of $13 for each photo. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be created in black and white.

All scientific material is reviewed by the editor and three members of the Publication Committee. Depending on their content, other types of articles are usually only reviewed by the editor and should still be mailed to the same address. All articles should be addressed to: Stephen D. Ward, M.D., Editor, *West Virginia Medical Journal*, Charleston, WV 25364.

If you have questions or need more information, phone Nancy L. Hill, managing editor at (304) 925-0342.

President's Page

HOW COME?

I am keeping my comments brief this month so that our new executive director, Evan Jenkins, can make a few remarks. There are two subjects, though, that I feel compelled to discuss.

FIRST - By law in this state, pharmacists are required to dispense generic medicine. This is supposed to help our patients save money. If this is the whole reason, why aren't the retail pharmacists required to pass all the savings along to the patients?

If a brand name drug costs the pharmacy $20 and the patient pays $25, the generic costs $10 and the patient pays $20. It is obvious that large windfall profits are being made at the pharmacy level.

Now, I am not accusing all pharmacies of this, but, I know that this is happening. HOW COME?

SECOND - I find it hard to believe that we, as physicians, let insurance companies base their payment rates on Medicare rates. Even Workers' Compensation pays better.

Medicare has always been low and as the specialists know, they get less and less each year. I don't think 100% of Medicare is such a bargain. HOW COME?

David W. Avery, M.D.

This is YOUR Association

I want to express my sincere appreciation to the Executive Committee, Council and the membership for giving me the opportunity to lead this impressive organization. Since the initial interview, I have gained a keen awareness of the WVSMA's strong physician leadership and deep involvement of its members.

During my first weeks as executive director, I have enjoyed attending several of the component society meetings to visit with members and hear your ideas. These visits have also given me the chance to share my vision of how the WVSMA can be the organization of choice for West Virginia physicians. I look forward to interacting with many more members throughout the summer and at the WVSMA's Annual Meeting at The Greenbrier.

If you have not already made plans to attend, I encourage you to register for this year's Annual Meeting. Please see the General News section and pages 134-139 for more details about some of the events, as well as a registration form and a preliminary program.

I am currently dedicating a significant amount of time and energy to a comprehensive review of the internal operations of the WVSMA. Every member of the staff has been extremely pleasant and helpful during this transition period. The WVSMA is fortunate to have such a dedicated, professional and committed staff.

I am eager to work with the membership to build an organization that possesses a strong program of work for advocacy on behalf of its members and the entire medical community. Let me assure you the WVSMA will maintain the strongest possible commitment to its core purpose set forth in our Constitution and Bylaws, and we will dedicate our resources toward programs which best carry out that mission.

This month, every WVSMA member will be mailed a membership survey asking for input into your views of our organization's operations. The future of WVSMA is dependent on our ability to provide a clear return on investment to you the member. Please take a moment to complete the survey and send it back. Your feedback will help insure that our program of work is on track and that we are engaged in the activities you desire most from YOUR Association.

Evan Jenkins
WVSMA Executive Director

Cottage industry

Is Medicine fated to be no more than a cottage industry at its organizational best? So far, efforts at shaping the business of Medicine via the machinery of modern, high-tech business have failed dramatically, but efforts continue in attempts to mold us into a successful business configeration.

Nationally, medical costs are increasing about three to five percent a year in spite of managed care, government regulations, HMOs, PPOs, IPAs or any number of scrambled initial organizations. Managed care companies have gone bankrupt or have withdrawn from numerous markets. The past several years have been very poor ones financially for all health care insurers and many are expected to abandon the health care market.

Socialized Medicine, the coveted Valhalla of Hillary and other planners waits on the side lines, of course, with its promise of *political* control of medical costs. The fiction of likely cost control success of that promise is highlighted every day by the total failure of politicians to do anything but immediately give in to any organized group disposed to apply even the slightest pressure on any subject. Our present crop of politicians is more vulnerable to pressure than any in our political history. The present Administration does not even wait for groups to organize to apply their pressure; polls and focus groups are enough to start whatever giveaway seems desired.

Patients are showing a surprising sophistication about their preferences for medical care plans. When given the opportunity for free choice of the type of care they want, subscribers overwhelmingly opt for plans giving them free choice of physicians. It is only when bottom-line-centered company or union sponsored plans are bestowed on employees that restrictive managed care plans survive. Initially, these are accepted with gratitude. The awful truth that these plans are just fine until someone in the family gets sick arrives a bit later.

Medical costs keep going up because the demand for care is infinite. The demand for care is infinite because no object, no luxury, no commodity, nothing in this life can ever approach the value of life itself. How many brains does it take to figure that out? What mathematician is going to construct a formula to control costs with one of the constants in the equation at infinity? Can Bill Gates do it on his computer?

Controlling medical costs is like squeezing on a partially inflated balloon. You grab one protuberance to deflate it and a bubble appears immediately at another spot. The latest example of this is the rapid rise of pharmaceutical costs. This followed directly on physicians' managed-care-demanded efforts at reducing hospital lengths of stay and office visits. There was, indeed, a simultaneous, substantial reduction in hospital and physician costs.

Business leaders and government planners continue to scratch their collective heads to near baldness over the dilemmas. There just might be no answer to the problem of controlling medical care costs aside from returning to that old-fashioned system where patients in consultation with their doctors decided what was best and what was affordable for them. It was a pretty good system a while back.

There are more options and, particularly more expensive options today that would require some variant of the cottage industry style of medical care cost control. Differing levels of what might be affordable would surely be a major stumbling block. The alternative, however, might well be indifferent and mediocre care for all along with a halt to any medical research which might lead to some new but expensive treatment.

It is unlikely that the clock will be turned back in any way for medical care. It is important to note, however, that the great majority of present day medical care cost control problems are the direct result of misguided efforts in the past to make improvements. Our cottage industry past was a much more satisfactory arrangement than that which we now have or that we have heard discussed for our future.

Stephen D. Ward, M.D.
Editor

Letters To The Editor

Car wash soap?!

CAR WASH SOAP?! It is bad enough that an unreasonable provider tax is still on the books, but it was literally "adding insult to injury" in the manner that the Legislature considered any change in this tax.

The proposed reduction of the provider tax for physicians and dentists was attached as a rider to a bill, the main purpose of which was to exempt car wash soap from the six percent sales tax.

While some of our colleagues have left the state to set up offices in contiguous states and elsewhere, most of us wish to stay in West Virginia because of the many other benefits that we get from practicing in this area. I realize that there are some physicians who don't believe that the state is being abusive in its treatment of us and who believe as stated in a WVSMA news release that ". . . there does appear to be some sentiment to remove this tax by members of the Legislature . . ." I simply cannot share in this optimism.

When the six percent sales tax on food was reintroduced into the state, the supermarkets did not pay this tax. We all did. They simply added the tax to our total food bill and collected the tax for the state. Why can't we do the same? Is there some sort of law or constitutional prohibition against this? Why should physicians and dentists have more of a social responsibility to fund the state Medicaid program than the population as a whole? Could we look into the feasibility of simply passing the provider tax, whatever the amount, onto the patients?

Is there a special tax levied on attorneys for the purpose of paying for the cost of running the courts? Is there a special tax on police officers and other law enforcement personnel to pay for the cost of running the police stations and jails? Is there a special tax on firemen to help pay for the upkeep of the fire fighting equipment? Of course not! It would be unfair to have such a tax. Why then is the provider tax tolerated?

CAR WASH SOAP? I don't think so!

Thomas J. Romano, M.D., Ph.D., F.A.C.P.
Wheeling

Australian physician concerned about excessive use of restraints, stun technology by prisons, police

I write as an Australian physician (internist) deeply committed to human rights and the dignity of all people regardless of race, color or creed.

I am deeply disturbed about a report I read regarding the inhuman and degrading use of restraints in prisons in West Virginia, and also the use of gas and chemical sprays, in particular pepper spray. In addition, electroshock devices are used.

I strongly recommend that the Justice Department ban the use of such devices and methods of restraint. Such methods denigrate the dignity and worth of the victim and engenders despair and hatred, and is unchristian.

Please consider this comment positively and take steps to change these practices.

I would appreciate your replies.

Dr. W. J. Quilty
2 The Boulevard
Shepparton
Victoria
Australia 3630

Intercepted Communications

Editor's Note: *This letter was shared with us by its author, M. Ayoubi, M.D., of Charleston, who encourages readers to express their opinions to Mrs. White on this issue and others that may be affecting their practices.*

March 29, 1999

Mrs. Barbara White
Director of Technical Assistance and Customer Service
West Virginia Department of Health and Human Resources
State Capitol Complex, Building 6
Charleston, West Virginia 25305

Dear Mrs. White:

I am enclosing a copy of our invoice for the Rotavirus vaccine. As you can see, our cost per dose is $41. However, our actual cost for administration includes additional costs for staff time to place the orders, receive and verify the shipments, store it in a designated place, periodically check expiration date, temperature and condition, provide vaccine information to the parents and obtain their consent and signature. The staff time also involves administering the vaccine, verifying lots and dates, recording the administration on patients' charts and patients' immunization booklets, and keeping office record of every vaccine administration for 21 years. My staff must also submit invoices and record payment for services.

It also involves physician's time to discuss the benefits of the vaccine, answer questions and verify parents' understanding and appropriate administration. There is also the cost of the cash outlay from the time the product is purchased until payment for service is received.

Your allowance for payment of $43.80, allowing $2.80 above supplier's invoice, does not even cover handling costs, and it doesn't even come close to covering professional contact, administration and record keeping. Even a department store wouldn't consider selling a product for such a trivial amount of markup.

I would appreciate your reevaluation of your payment allowance for this vaccine, considering the issues I have brought to your attention in this letter, and any feedback you have for me.

Sincerely,

M. Ayoubi, M.D.

Special Article

Hepatitis C: The physician's responsibility?

Q. I've received a letter from a hospital stating a patient may have received a "questionable blood" transfusion and could be a carrier of the Hepatitis C virus. What should I do to be sure I handle this case correctly?

A: The Food and Drug Administration requires blood centers and hospitals to notify transfusion recipients that may have received contaminated blood. Hospitals may send notification letters directly to patients or to the patients' physician, who then has the responsibility to follow up with the patient.

If you receive such a notification letter, risk management experts suggest reviewing the patient's record, documenting any information received and taking the following actions:

- Provide sufficient communication, both verbal and written, so the patient can make any necessary decisions.
- Offer a basic explanation of the need for testing and counseling.
- Provide a list of alternative testing procedures and counseling services including any requirements and restrictions.
- Advise the patient on protecting his/her liver from further damage by avoiding alcohol, herbal medications or over-the-counter medications (unless prescribed by a physician).

You also may want to determine how the hospital(s) in which you practice will notify affected patients so that you will be prepared.

Future liability

Risk managers suggest health care professionals add drug use and sexual activity information to their patient histories. This can help determine if you should suggest a patient be tested for the Hepatitis C virus or educated on the potential risks they may face.

Before a medical procedure that may require a blood transfusion, you should inform the patient about the procedure's risks, benefits and alternatives, as well as information concerning the Hepatitis C virus. In obtaining this informed consent, you should document any indications for blood administration.

Physicians insured by Medical Assurance, WVSMA's endorsed professional liability carrier, may contact the company's Risk Resource Center for answers to liability questions and/or risk management by calling (800) 282-6242 or via e-mail at rmhelp@maih.com.

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- Participate in special issues forums.
- Network at state and regional caucuses.
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For more information on how to register, call **800 626-3211** and **ask for the Department of Organized Medical Staff Services** or e-mail us at **omss@ama-assn.org**.

* Must be an AMA member

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An estimate of prostate cancer prevalence for a demographically similar workforce population

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Abstract

To obtain an estimate of prostate cancer prevalence when screening is applied to a workforce, we conducted a search of the English world literature from West Virginia University. Thirty-one papers which met selection criteria for screening were followed by histopathologic diagnosis. Publications using Prostate Specific Antigen (PSA) as a screening test were reviewed. The data from these papers were combined. Population characteristics were then selected to represent the demographics of a working population. Prostate cancer prevalence estimates for the demographics of a working population were calculated using a weighted mean after relevant studies lacked homogeneity and therefore failed meta-analysis. The expected prevalence of prostate cancer in a workplace surveillance population is 2.03% (95% C.I. from 1.69% to 2.37%). This information is useful to entities considering workplace surveillance. Selection bias, geographic location, and uncertainty in prediction of a representative workforce population may strongly influence estimates.

Introduction

Each year thousands of men undergo prostate screening tests as a part of the routine physical examination or when being seen for other health problems. Current recommendations by the American Cancer Society are for annual screening Prostate Specific Antigen (PSA) tests for men greater than 50 years old (1).

Prostate cancer will be diagnosed in more than 200,000 men yearly; 41,800 will die of the disease, making it the second leading cause of death after lung cancer. Prostate cancer accounts for 15% of cancer related deaths in men (2,3).

Screening recommendations are made in hope of detecting prostate cancer in an early stage so that appropriate medical intervention can be made which ultimately will cure the disease. Prostate cancer screening has been promoted as a reasonable and effective workplace health promotional intervention (4).

A long-standing concern about prostate cancer surveillance is absence of population evidence that available interventions result in decreased morbidity, increased life expectancy, or improvement in quality of life (5,6). The ultimate justification of a screening test is the cost effective reduction in mortality and morbidity which an intervention subsequently provokes. In the absence of increased survival or decreased morbidity, the application of a screening test fails to meet standard public health principles of medical surveillance (7). In fact, concern has been expressed that therapeutic interventions provoked by surveillance may increase morbidity without improvement in quality of life or survival.

The National Institute of Health has launched a 15-year prospective multi-center Prostate Cancer Detection Project which addresses the questions of screening and treatment effectiveness (8). A secondary need exists for sound data on the prevalence/incidence of prostate cancer in the general public when undergoing screening. For example, data concerning expected rates are essential if environmental relatedness of the disease is to be assessed. Current screening recommendations are based upon non-randomized studies whose interpretations are complicated by the many unknowns surrounding the natural history of prostate cancer.

There is a real need for sound prevalence data, particularly if we are to recommend screening in settings such as the workplace where population outcomes will be closely scrutinized for efficiency and utility as well as for deviations from expected norms that might be hypothesized to reflect environmental causation.

When routine screenings are performed, they occur over a period of time. During this time frame,

detectable disease occurs adding incidence to prevalence. Some disease present in the survey population may be missed. The expected outcome of screening is prevalence at outset plus any new incident disease during testing, minus any existing disease missed by the survey.

This outcome creates the "harvest" which closely approximates prevalence when survey tests are sensitive and administration time is limited. Screening closely approximates incidence when periodic testing is performed. This is primarily because frequent screening decreases prevalence at onset if known existing cases are excluded.

In our study, the expected harvest of prostate cancer was estimated when screening is performed on the general public. This estimate can be applied to the workforce of an industrial setting. From a public health perspective, the data on the expected number of prostate cancer cases are crucial to the identification of risk factors (or protective behaviors) for developing prostate cancer. Since physicians feel uncomfortable ruling out the diagnosis of prostate cancer in a male greater then 50 years old with a digital rectal exam (DRE) alone, the Prostate Specific Antigen (PSA) test is used alone or in combination with the physical examination. Prostate Specific Antigen is relatively inexpensive ($17-$112), easily administered, and hence amenable to worksite intervention (9,10).

Materials and methods

An analysis of the published English literature was performed. Included was a Medline search using Grateful Med ®, Cancer Lit ® CD ROM, and current journal articles, from 1988 through 1997. Search terms were prostate cancer, prostate specific antigen and cancer screening.

A total of 127 relevant journal abstracts were reviewed. Selection criteria for further review included the following:

1. The total number of persons enrolled to be used as the denominator;
2. PSA testing performed;
3. Number of prostate cancers detected; and
4. All cancers must be histopathologically documented.

Of the 127 abstracts, 31 papers were chosen for closer analysis and Table 1 shows the data recorded. For each study, calculations of the harvest of prostate cancer were made for the tested population. Using the group of studies combined as a whole, harvest data were calculated for the tested population.

After examining the data, criteria were developed to resemble the age distribution of a working population most likely to undergo prostate cancer screening. Based on present screening recommendations, this is males older than 50. Since prostate cancer increases markedly with age, exclusion of males likely to be retired is necessary. This frequently turns out to be persons in their eighth decade of life or older (11). For workplace comparability, we limited our population to ages 50-71.

In addition, the survey population needed to be from the general public for inclusion. They should not be selected from a referral base, which implies population selection factors such as previous abnormal screening (rectal exam, or PSA). Inclusion of pre-screened groups would give a disproportionately high percentage of prostate cancer. Since the PSA has become the screening test of choice in industry, studies which did not use PSA in screening were excluded. Where identifiable subpopulations within an excluded study (when the study was considered as a whole) met inclusion criteria, the subpopulations were included despite the larger population's exclusion. Finally, publications analyzing identical populations represent duplicate data and were therefore excluded.

Meta-analysis was attempted but failed because of statistically different results between the extracted data populations. Reasons for these statistical differences were explored. Ultimately, a weighted mean was calculated using screened populations as denominators with the figures for biopsy-proven prostate cancer as the numerators.

Table 1. Data Recorded From the 31 Studies on Prostate Cancer.

Study Title
Year Performed
Year Published
Author
Where Published
Location
Selection Criteria
Prevalence vs. Incidence Plus Prevalence
Were Digital Rectal Exams Performed and Result
Prostate Specific Antigen Test and Results
Type of PSA Assay Used
Transrectal Ultrasound (TRUS) Used and Results
Number of Subjects Undergoing Biopsy (Direct of Under Ultrasound)
Diagnosis of Prostate Cancer
Population Tested
Age of Population Tested
Age Distribution of Those with Prostate Cancer

Results

Tables 2a and 2b summarize the 31 studies selected. As mentioned in the footnotes of these tables, some of the studies are further broken down into two or three studies to maximize qualifying data (Table 3).

This extraction of data preserved data which might have been lost if exclusion criteria were applied to the whole study. Table 4 shows studies excluded from our analysis and the reason for exclusion. It should be noted that exclusion of studies does not necessarily imply design flaws. Most studies were excluded through failure to meet criteria for a workplace population at increased risk for development of prostate cancer.

The total number of people in the tested population was 275,611 with an aggregate prostate cancer harvest of 1.7%. The harvest ranges from 0.0% to 22.6%. The results in Tables 2a and 2b include data which are clearly skewed by selection of the population that was tested. Table 5 presents the studies which fulfill selection criteria for a working population. The total number of persons tested was 13,799 with an aggregate prostate cancer harvest of 2.5%. The harvest ranged from 0.3% to 3.6%.

Table 2a. Summary Data From Studies of Prostate Cancer Patients.

Main Author	Year Pub.	# Tested	# Diagnosed	% Per Tested Populat.
Mettlin	Jan. 96	2,999	84	0.028
Kantrowitz	Oct. 95	1,219	12	0.01
Egawa	Aug. 95	1,189	16	0.013
Schroder	July 95	2,028	42	0.021
Potosky'*'A	Feb. 95	100,000	1848	0.018
Potosky'*'B	Feb. 95	100,000	1310	0.013
Gann	Jan. 95	14,916	###18	0.001
Abramson	Aug.94	564	18	0.032
Bretton	July 94	1,027	39	0.038
Kirby	Jan. 94	568	11	0.019
Catalona'*'A	Aug. 93	1,0251	296	0.029
Catalona'*'B	Aug. 93	266	60	0.226
Gerber'*'A	Jan. 93	2,005	'+'19	0.009
Gerber'*'B	Jan. 93	2,131	'++'19	0.009
Imai	Vol. 51,'93	9,067	87	0.010
Gustavsson	Dec. 92	1,782	65	0.036
Brawer'*' A	Mar. 92	822	22	0.027
Brawer'*' B	Mar. 92	427	10	0.023

*' Studies broken down further for isolation of variables

###'Eighteen men were diagnosed with prostate cancer after the first year of study (i.e. initial harvest plus some incidence)

+' '++'68% of the total amount of prostate cancer was diagnosed in the first year (56 dx of prostate cancer divided by 2 study groups multiplied by 68% which equals 19) (i.e. initial harvest plus a minimal amount of incidence)

Calculations

Using the data in Table 5, a meta-analysis was attempted. There was no homogeneity for all 10 studies; and therefore, no common proportion could be estimated.

Three statistically different homogeneous strata were identified. If there were a reason to stratify the studies then a common proportion could be assumed; however, none was noted despite investigating geography, exclusively working populations, and the specialty department performing the study. Table 5 demonstrates the lack of medical reasons for stratification.

Having failed meta-analysis, a weighted mean effect of 2.03% (95% C.I. from 1.69% to 2.37%) was calculated.

Discussion

The harvest of prostate cancer in a tested population is 2.03%. When industry successfully screens a working population ages 51 to 71 years old, the figure for the expected prostate cancer prevalence is 2.03%. This decreased figure is slightly higher than prostate cancer harvest across the 275,611 whose screening harvest is known.

Having not met the criteria of a meta-analysis, it is important to consider this result in the context of its range 0.3% to 3.6%. This range reflects the harvest in those who accepted invitations and went through surveillance to biopsy when appropriate and is probably most closely aligned with the information needs of corporate planners.

There are a number of levels of uncertainty in these numbers. From an epidemiological standpoint, many of the studies fell short of acceptable standards. Most notable is that many of the studies fail to provide the total number of population invited. Due to the fact that it is difficult to determine exactly how many people a public announcement reaches, most studies failed to report the number of people invited. All studies provided the number of people tested, but the response rate of those accepting the invitation to be screened, is unclear among these studies. The characteristics (health status, age, race, etc.) of those declining to be screened is not known, making it difficult to ascertain sources of bias.

Table 2b. Summary Data From Studies of Prostate Cancer Patients.

Main Author	Year Pub.	# Tested	# Diagnosed	% Per Tested Populat.
Babaian	Mar. 92	**' 2425	88	0.036
Labrie	Mar. 92	1002	57	0.057
Thomson	Apr. 92	2736	5	0.002
Chadwick	Sept. 91	472	7	0.015
Moon'*'A	Sept. 91	190	0	0.000
Moon'*'B	Sept. 91	224	5	0.022
Mettlin	June 91	2425	52	0.021
Catalona	Apr. 91	1653	37	0.022
Vallancien	Mar. 91	100	14	0.140
Babaian	1991	287	10	0.035
Littrup'*'A	Feb. 91	368	'^^'10	0.027
Littrup'*'B	Feb. 91	400	'^^^'12	0.030
Palken	Jan. 91	323	23	0.071
Muschenheim*A	v. 21#6 '91	342	16	0.047
Muschenheim*B	v. 21#6 '91	223	4	0.018
Perrin'*'A	1991	863	3	0.003
Perrin'*'B	1991	370	6	0.016
Perrin'*'C	1991	370	67	0.181
Cooner	June 90	1807	263	0.146
Teillac	Vol. 18, '90	685	22	0.032
Normura	June 88	6860	103	0.015
Cooner	Apr. 88	225	28	0.124
Totals		**275,611**	**4,808**	**0.017**

*' Studies broken down further for isolation of variables

^^'Plus 2 cases of dysplasia ^^^'Plus 3 cases of dysplasia

**'The number of the total population was over a 3 year period with annual exams occuring each year, resulting in initial harvest plus 3 years of incidence collected with an annual exam.

Furthermore, who responded? Although age groups were chosen to reflect a working population at risk, actual work status is unknown in all but one study (4). Are responders with extra time (retirees) over represented? Or those with symptoms? Or those who have not yet been tested and therefore less likely to have symptoms?

In general, we suspect most biases would increase the estimated harvest in the present circumstance because of greater prevalence in the older age group. This assumption would change if screening becomes more generally accessible.

How well do the studies selected after the exclusion criteria have been applied resemble a working population? Many workers retire at age 65, and the age range selected here would bias toward higher harvest percentages. It could also be argued that retirement age is advancing upwards (at least in the United States) and that a group that includes those in the seventh decade of life is becoming more representative of a working population (12).

One would also have to consider the racial make-up of the working population. The prevalence of prostate cancer is apparently lower in Japanese men and higher in African-American men. This difference is hypothesized to be

Table 3. Rationale for Dividing Up Studies (Variable Isolated by Splitting Up Study).

Potosky	Race: A = White; B = African American
Catalona	Two Pre-screened Populations: A = No hx of Prostate Ca or Prostatitis B = No normalities (all abnl DRE, PSA or TRUS)
Gerber	Two Different Geographic Populations: A = Texas; B = Illinois
Brawer	Age: A = 50-70 years old; B = greater than 70 y.o.
Moon	Age: A= 40-49 y.o.; B = greater than 50
Littrip	PSA assay: A = Tandem R (Hybritech) S.D. CA; B = Pros Chek Yang Labs; Bellevue WA
Muschenheim	Two Different Geographic Populations: A = Based out of Oneida City Hospital B = Based out of Hamilton, NY
Perrin	Subject selection pool: A = Quinquennial Health Check; B = Consult a General Practitioner; C = New Urological Patient

Table 4. Studies Excluded.

Age of Patients < 50 or > 71	PSA Not Performed	Referred Patient Population	Duplicated Patient Population
Egawa	Perrin B	Perrin C	Babian**
Schroder	Littrup A*		
Potosky A	Littrup B*		
Potosky B			
Gann			
Abramson			
Bretton			
Catalona A			
Catalona B			
Gerber A			
Gerber B			
Imai			
Brawer B			
Labrie			
Thomson			
Moon A			
Catalona			
Vallancien			
Babaian			
Palken			
Muschenheim A			
Muschenheim B			
Teillac			
Normura			
Cooner			

***Littrup did not use P.S.A. in decision to bx.**

****Babian '92 and Mettlin '91 both used identical study populations (American Cancer Society NPCDP data). Babian was excluded instead of Mettlin because Babian included some incidence data with initial harvest data.**

due to differences in hormonal androgen secretion and metabolism in differing ethnic groups (13). The utility of ethnic/racial risk factors, independent of socioeconomic status has been questioned in some quarters (14), but best present evidence suggest future harvest predictions for prostate cancer screening would improve with ethnic and racial data. Self-selection bias presents an additional measure of uncertainty, which will change if more men are surveyed routinely.

An interesting finding is that the estimated harvest increased after applying our exclusion criteria. This is contrary to expectation and we offer no explanation. It does not appear that the final data (Table 5) are from a period of time when testing was more intense (1991-93) relative to the summary tables (Tables 2a, 2b). If anything, Table 5 appears to reflect a slightly younger age group, where the prevalence of prostate cancer would be expected to be less. One possibility is that stronger study designs identify a higher prevalence of disease. If this is the case, the explanation relates to some unknown detection bias.

As long as the public is screened for prostate cancer, there will be a need to know the prevalence of (or more precisely, the harvest of) prostate cancer in a cross-section of the general public if comparisons of potential ecological significance are to be made. As we become more successful at preventing surgical complications and treating other comorbid conditions, prostate cancer interventions may then prove to decrease morbidity and mortality. Similarly physicians may be able to identify a subclass of prostate cancer that, if detected early is curable. The workplace is a convenient place to undertake detection strategies, and, as the U.S. population ages, prostate cancer prevalence data will become increasingly important.

On a final note, it is critical to be cognizant of the way the various professional groups develop their screening recommendations. The U.S. Preventive Services Task Force

(USPSTF) has epidemiologists and clinicians making screening recommendations. These are preventive medicine experts practicing preventive medicine. The USPSTF states "Routine screening for prostate cancer with digital rectal examinations, serum markers (e.g. PSA), or transrectal ultrasound is not recommended" (1).

Other organizations advocate a more aggressive screening approach (Table 6) (1). These organizations have a lower threshold at which they will invoke the use of public resources for unproven benefit. Their recommendations are worthy of consideration but do not reflect prudent use of an ever-shrinking healthcare dollar or prudent recommendations for patient care. Alternatively, the more aggressive recommendations, by virtue of their potential to improve prostate cancer research and development, may be wisely investing today's healthcare resources for decreased future prostate cancer morbidity and mortality. This sequence occurred with the development and modification of surgery and medical interventions for breast cancer - a disease whose natural history resembles prostate cancer in some ways, a glandular cancer with a

Table 5. Demonstration of the lack of medical reasons for stratification.

Stratification Group	Study	Location
Low values	Kantrowitz ('95)*	Cambridge MA
	Perrin A ('90)	Lyons France
Middle values	Mettlin ('96)	Multicenter: U.S. & Canada
	Kirby ('94)	London England
	Brawer A ('92)	Seattle WA
	Chadwick ('91)	North Bristol U.K.
	Mettlin ('91)	Multicenter: U.S.
	Moon ('91)	New Orleans LA
High Value	Gustavsson ('92)	Stockholm Sweden

Multicenter: U.S. & Canada = MI, OH, IL, MA, GA, TX, CA, OR, WA, Toronto

Multicenter: U.S. = NY, MI, OH, GA

* The only study from an Occupational Medicine Department and of a work force population. All other studies were from Urology, Oncology or Epidemiology Departments and were of general public populations and therefore not necessarily employed (i.e. no healthy worker effect).

Table 6. Prostate Cancer Screening Recommendations (1)

Organization	Recomendation
United States Preventive Task Force	Routine Screening not reccomended
Canadian Task Force on Periodic Health Examination	Routine Screening not reccomended
American Cancer Society	Digital rectal exam (DRE) @ age 40 and up, DRE plus PSA @ age 50 and up. For African-American men and those with a family history of prostate Cancer, DRE plus PSA @ age 40 and up.
American Urological Association	DRE @ age 40 and up, DRE plus PSA @ age 50 and up. For African-American men and those with a family history of prostate Cancer, DRE plus PSA @ age 40 and up. TRUS is not recommended as routine screening tool.
American College of Radiology	DRE @ age 40 and up, DRE plus PSA @ age 50 and up. For African American men and those with a family history of prostate cancer, DRE plus PSA@ age 40 and up.

more aggressive course in younger individuals. Improvements are likely to occur in invasive prostate cancer detection and treatment, and affect future recommendations.

The work survey population who will test positive are interesting from several perspectives. First, they face important choices in the face of tremendous scientific uncertainty, a trait they share with the general population screened in private clinics. Second, the predicted size of the worksite screening harvest populations is a moving target, probably affected by survey techniques, threshold for diagnosis and existence of competing access to testing in other settings. Third, it is unclear what work survey populations learn concerning the present state of knowledge about prostate cancer, its detection, treatment, treatment benefit and morbidity.

Conclusion

The workplace provides a highly advantageous setting for detecting prostate cancer. A relatively high but fluctuating percentage of the survey population will have the condition. The percentage is presently estimated at 2.03%.

Surveys that adequately inform workers of the uncertain present benefits of participation in prostate cancer screenings hold a potentially important role in public health.

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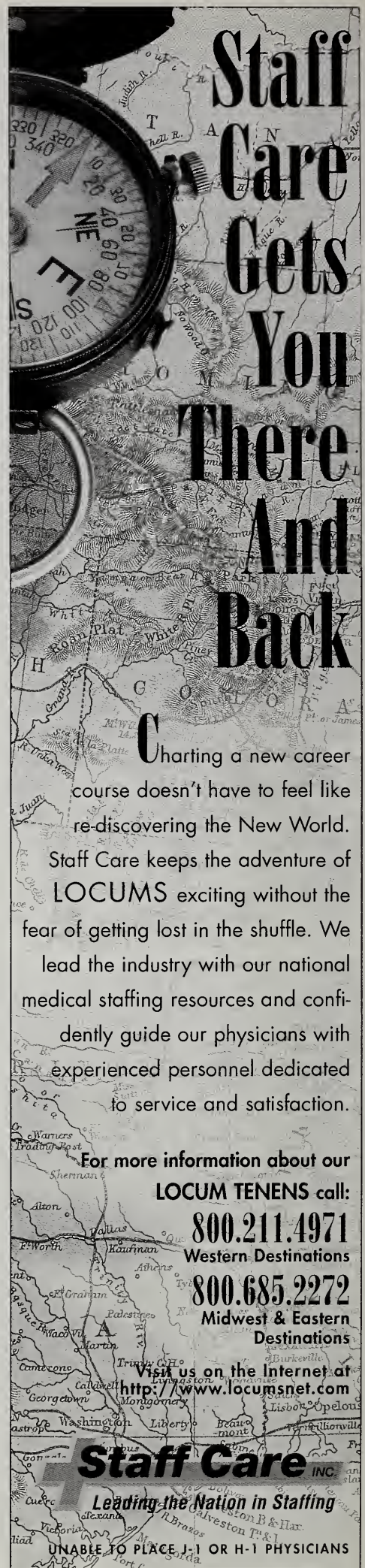
(An appendix of the 31 studies mentioned in this article, is available from the first author.)



Personality traits of incoming WVU medical students: Phase I gender findings

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The findings in this paper, in part, were presented at the 30th Annual Spring Conference of the Society of Teachers of Family Medicine (Boston, 1997) and the 24th International Congress of Applied Psychology (San Francisco, 1998).

Abstract

The purposes of this longitudinal research are to (1) identify personality traits and trait patterns of incoming WVU medical students; (2) reassess students shortly before their graduation; and (3) identify any trait or trait patterns which demonstrate significant correlations with choice of residency. Students (n = 181; 102 male, 79 female) were administered the Sixteen Personality Factor (16PF) Questionnaire during consecutive new student orientations (Fall 1995 and 1996). Findings of the first phase of this research demonstrate significant differences in traits between our medical students and the general population. The most compelling findings, however, involve personality trait differences between female medical students and their male peers. Beyond offering training implications, these early findings suggest the utility of the 16PF in defining trait patterns with medical students.

Introduction

Admission into medical school is an intensely competitive process and it is clear that successful applicants represent a distinct and venerable subset of our society. Indeed, a recent Harris poll identifies the physician as the most esteemed professional in our country (1).

Objective descriptions of physician personality, however, are limited. Investigations that have ventured to assess physician and/or medical student personality have often utilized either testing primarily designed for examination of pathology or measures that are not widely known or disseminated (2-5).

One exception is the California Personality Inventory (CPI) - a 480 item true/false test of personality standardized on normal populations. The CPI has been used in a number of studies involving medical students (6-8). A 1975 review suggests that preferences for specific residencies may be associated with personality and motivational factors (9). However, a more recent well-designed longitudinal study demonstrated no predictive ability for the CPI based on analyses of four classes of entering medical students compared with their later residency selections (10).

The Myers-Briggs instrument is another measure that has been used with medical students in an attempt to identify personality types and better understand specialty selection (11-14). However, the Myers-Briggs' Jungian personality types fall short of comprehensively identifying the distinct individual traits which shape personality. As an example, the Myers-Briggs shows poor correlation with measures of personal adjustment, social adjustment, and anxiety (15,16). Moreover, the Myers-Briggs' portrayal of dichotomous types (e.g. introversion vs. extroversion; judging vs. perceiving) rather than continuous personality dimensions or traits is often questioned (17). The problems associated with dichotomous measures along with an absence of normative data have prevented the instrument from being classified as a true psychological test (17).

Methods

The Sixteen Personality Factor Questionnaire - Fifth Edition (16PF) was chosen due to the intent of its design (i.e., to comprehensively measure the normal variants of personality) and because of its wide acceptance in industrial and organizational, clinical and counseling, as well as educational settings (18).

The 16PF Fifth Edition was published in 1993 after an extensive re-standardization (16,19). The questionnaire is composed of 185 multiple-choice items that measure 16 primary source traits along a standard ten (STEN) continuum. A sten of 1, therefore, represents the smallest measure (indeed, the polar opposite) of a given trait while 10, indicates the greatest magnitude of a given trait (Figure 1).

The standardization sample falls along a normal curve with respect to frequency distribution along sten points for each personality factor. The mean sten score for each source trait is 5.5. Reported test-retest reliabilities (at two-month intervals) range from .56 to .79 (M = .70) and the average internal consistency for the primary source trait scales range from .64 to .85 (M = .74) (16). In addition, respectable construct and criterion validities for the instrument are reported (16,20).

16PF® Fifth Edition Individual Record Form

Profile Sheet

Instructions: Write the sten score for each factor in the second column. Starting with Factor A, place a mark over the spot representing the appropriate sten score. Repeat for each factor. Connect the marks with straight lines.

Name _____

Date _____

PRIMARY FACTORS

Factor	Sten	Left Meaning	Standard Ten Score (STEN) ←Average→ 1 2 3 4 5 6 7 8 9 10	Right Meaning
A: Warmth		Reserved, Impersonal, Distant		Warm, Outgoing, Attentive to Others
B: Reasoning		Concrete		Abstract
C: Emotional Stability		Reactive, Emotionally Changeable		Emotionally Stable, Adaptive, Mature
E: Dominance		Deferential, Cooperative, Avoids Conflict		Dominant, Forceful, Assertive
F: Liveliness		Serious, Restrained, Careful		Lively, Animated, Spontaneous
G: Rule-Consciousness		Expedient, Nonconforming		Rule-Conscious, Dutiful
H: Social Boldness		Shy, Threat, Sensitive, Timid		Socially Bold, Venturesome, Thick-Skinned
I: Sensitivity		Utilitarian, Objective, Unsentimental		Sensitive, Aesthetic, Sentimental
L: Vigilance		Trusting, Unsuspecting, Accepting		Vigilant, Suspicious, Skeptical, Wary
M: Abstractedness		Grounded, Practical, Solution-Oriented		Abstracted, Imaginative, Idea-Oriented
N: Privateness		Forthright, Genuine, Artless		Private, Discreet, Non-Disclosing
O: Apprehension		Self-Assured, Unworried, Complacent		Apprehensive, Self-Doubting, Worried
Q_1: Openness to Change		Traditional, Attached to Familiar		Open to Change, Experimenting
Q_2: Self-Reliance		Group-Oriented, Affiliative		Self-Reliant, Solitary, Individualistic
Q_3: Perfectionism		Tolerates Disorder, Unexacting. Flexible		Perfectionistic, Organized, Self-Disciplined
Q_4: Tension		Relaxed, Placid, Patient		Tense, High Energy, Impatient, Driven

Figure 1. Primary Source Traits

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Procedures

During orientations at the West Virginia University School of Medicine in August 1995 & 1996, 181 medical students were group administered the 16PF 5th Edition Questionnaire (see Table 1 for class demographics). Only two students opted not to participate and one additional questionnaire was never completed (all from class of 1996).

Students were informed that they would again be asked to complete the questionnaire shortly before their graduation and that this would enable analysis of the data relative to individual residency choices.

Table 1. Demographics for entering classes of 1995 and 1996.

Class of 1995

gender		*age*		*race/ethnicity*	
males	58	mean	23.3	White/Caucasian	83
females	36	range	20 to 39	Asian	10
		mode	22	African American	1

Class of 1996

gender		*age*		*race/ethnicity*	
males	44	mean	22.85	White/Caucasian	69
females	43	range	20 to 31	Asian	12
		mode	22	African American	5
				Native American	1

Results

In analyzing personality traits and trait patterns, the investigators conducted a series of multivariate analyses of variance (MANOVA), univariate analyses of variance (ANOVA), and one-sample t-tests. Our students were found to be higher in reasoning, emotional stability, and liveliness than the general population.

Numerous findings comparing our female and male students were also identified (Figure 2). Our female students tested as being more warm, sensitive, socially bold and open to change. Incoming female students did, however, evidence less imaginative thinking, greater perfectionism and apprehension than their male student peers.

Discussion

The finding that our medical students test as having greater reasoning ability, more emotional stability, and more liveliness than individuals in the general population is not unexpected. Moreover, it intuitively follows that female students would demonstrate more warmth and sensitivity than their male peers. The testing revealed several additional gender differences which are curious, however.

Our female students, for example, demonstrate greater social boldness than their male student peers. They also demonstrate a greater openness to change (as opposed to being more conservative and attached to the familiar). While such findings challenge gender stereotypes, similar findings (using different measures) have preceded our own when assessing women in previously male dominated professions (5,21,22).

There are some gender findings, however, that warrant concern. Our female students show traits of perfectionism (over those of their male peers) along with greater apprehension and self-doubt. Females entering previously male-dominated professions may feel added pressure to excel and distinguish themselves over and beyond the rigors inherent to the chosen profession. Such pressures (real and perceived) can be significant; recent research has shown that women in previously male-dominated professions are more susceptible (than male peers in the same profession and women in traditional occupations) to a variety of negative physical and psychological sequelae (23).

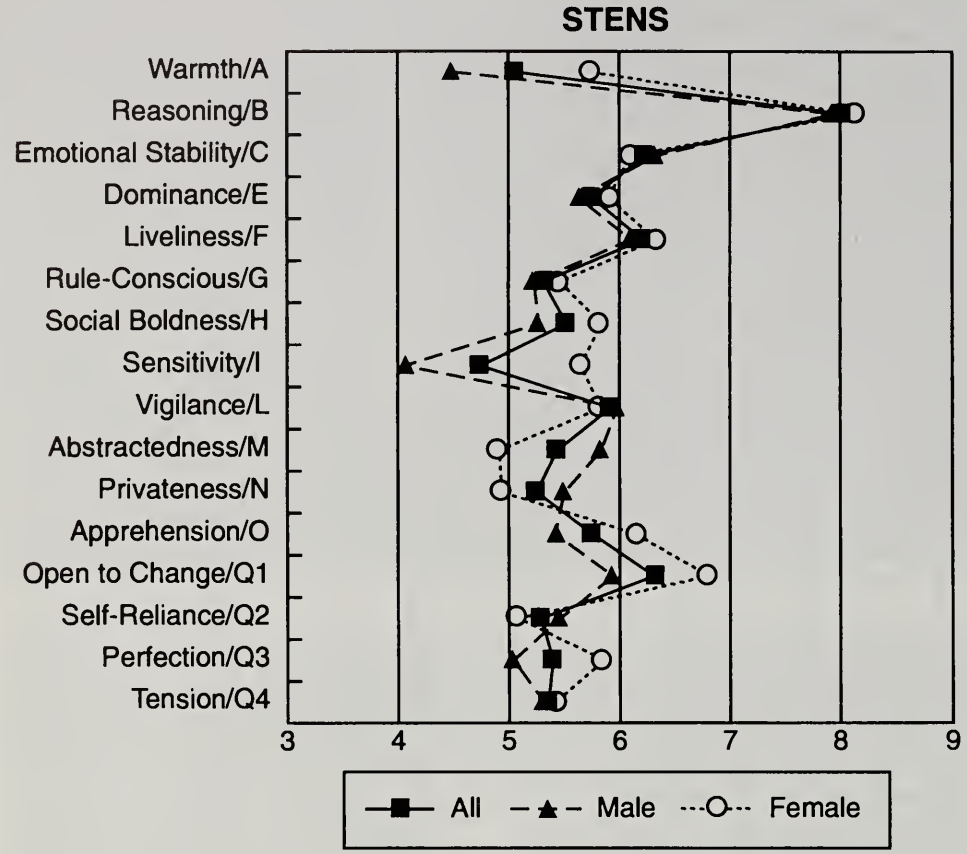
There are no doubt multiple reasons for this susceptibility. It has been suggested that non-traditional career women may feel threatened by the future prospects of balancing family obligations and career (23). Beyond physical and emotional health, career commitment may also be impacted as a consequence of such competing concerns (24).

These propositions (implying the potential high costs for women attempting to bridge demands of professional and family life) are supported by a longitudinal study of female physicians who participated in interview and personality assessments in 1967, 1975, and 1990 (25). Clearly, our medical schools may be well advised to attend to this growing evidence in offering specific programming (e.g. mentoring, focus groups) and/or curricular enhancements that may better promote healthy learning environments for women.

Conclusion

These findings complete the first phase of a longitudinal research effort to objectively identify the personality traits of students as they enter and exit medical school and choose specific residencies. Only a few studies have utilized the 16PF with medical students and most of these studies (except Eicke et al in 1993) (16) have occurred outside of the United States (26-28).

Given our encouraging results using the 16PF with medical students, we are hopeful that patterns may emerge predictive of eventual residency selection. Changing U.S. healthcare needs/systems, limited



	All $\bar{x}$	Male $\bar{x}$	Female $\bar{x}$
A	5.06	4.51**	5.76
B	8.03*	7.95	8.14
C	6.24*	6.34	6.11
E	5.76	5.64	5.91
F	6.22*	6.11	6.35
G	5.33	5.23	5.46
H	5.52	5.27	5.84†
I	4.76	4.08**	5.65
L	5.92	5.98	5.84
M	5.44	5.84	4.92**
N	5.25	5.50	4.94
O	5.75	5.43	6.16**
Q1	6.33	5.94	6.82**
Q2	5.30	5.47	5.09
Q3	5.40	5.05	5.86**
Q4	5.36	5.31	5.43

* significance at the $p < .001$ level comparing medical students to general population norms.
** significance at the $p < .01$ level comparing male and female medical students.
† significance at the $p < .05$ level comparing male and female medical students.

Figure 2. Mean STEN scores for incoming medical students, male medical students, and female medical students.

teaching resources, and a student-centered focus all call for methods that will assist earlier identification of a student's proclivity for primary care or specialty medicine.

To date, personality traits associated with residency selection and medical specialty career choice have not been reliably measured (29).

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(Please contact first author for other references listed in this article.)

Merkel cell carcinoma: An aggressive neoplasm

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Abstract

This article presents a rare case of Merkel cell carcinoma (MCC) of the skin. This tumor is also known as trabecular carcinoma or cutaneous small cell undifferentiated carcinoma (CSCUC). This patient had a palpable non-tender mass in her right upper thigh and a large palpable lymph node in the right inguinal area. Microscopic examination revealed Merkel cell carcinoma (MCC) in the skin of the upper thigh as well as in the inguinal lymph node. Immunoperoxidase stains confirmed the diagnosis. Due to its aggressiveness and very unfavorable prognosis, prompt diagnosis and adequate treatment are essential. Wide local excision with adequate margins followed by radiation therapy is the treatment of choice.

Introduction

MCC is a very rare primary skin tumor first reported by Toker (1) in 1972 when he identified fives cases that histologically resembled metastic carcinomas of other organs. Dr. Toker thought that this primary skin tumor originated from special receptor cells, know as Merkel cells, which are found in the basal layer of the epidermis. These cells were discovered in 1875 by Professor F. Sigmund Merkel, a German histopathologist.

However, this theory has recently been contradicted. Scientific papers by Merot et al (2) and Isimbaldi and colleagues (3) both suggest that this tumor may actaully originate from squamous cells, skin adenexal cells, and melanocytes. The tumor can be properly diagnosed microscopically by using immunoperoxidase stains.

Due to its aggressiveness and poor prognosis, the treatment of choice for MCC is wide local excision with adequate margins followed by radiation therapy.

Case report

A 74-year-old woman had a tumor 5 cm. in diameter removed from her right upper thigh on January 30, 1998. She had first noticed this lump approximately one year before the surgery.

A large right inguinal lymph node, measuring 6 cm. in diameter, was also identified and removed. Physical examinations, including CT scan were all within normal limits.

She refused any further treatment.

Results

Figure 1 shows trabecular and diffuse arrangements of tumor cells. The overlying epidermis is not involved by the tumor.

Figure 2 shows tumor cells with scanty cytoplasm and round nuclei with dense and uniformly distributed chromatin and small nucleoli. The tumor nests are separated by delicate fibrous tissue. Pseudorosettes, mitotic activities and lymphoid infiltrates are identified.

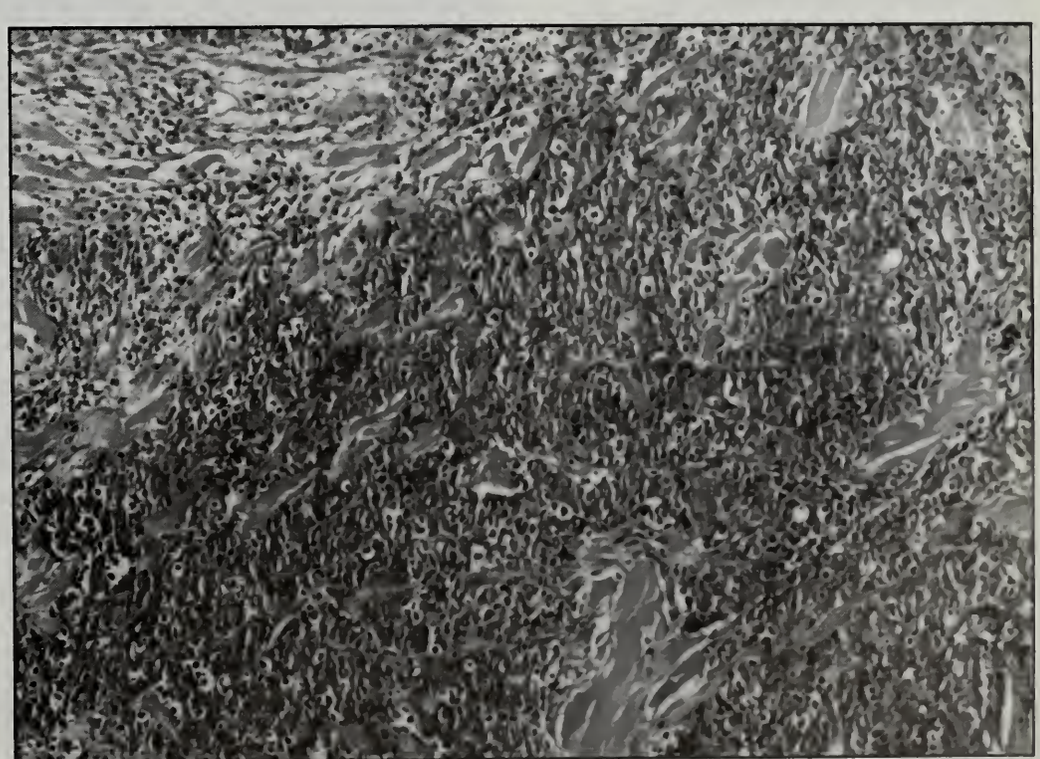

Figure 1. Tumor cells show trabecular and diffuse arrangements. Lymphoid infiltrates and fibrous tissue bands are also identified.

Figure 2 also shows that pyknotic nuclei and nuclear fragments.

Several immunoperoxidase stains were performed showing positive stains for NSE (neuron-specific enolase), chromogranin, synaptophysin, and low molecular weight cytokeratin and negative stains for S-100, HMB-45, LCA (lymphocytic common antigen), and desmin. Characteristically, the tumor shows cells with dot-like staining with antibodies to low molecular weight cytokeratin (Figure 3).

Discussion

In 1875 when Professor Merkel demonstrated touch-cells or "Tastzellen" in the snout skin of pigs and moles, he postulated that these cells had functioned as mechanical receptors from amphibian to man (6).

These specialized cells, which are now known as Merkel cells, are found in the basal layer of the epidermis of the skin, in the oral mucosa, and in the bulge region of the hair follicles (7). They are not detected by routine histological methods. However, they can be detected by silver stains. Merkel cells contain neuron-specific enolase in their cytoplasm (7). The precise functions of these cells are not known, but recent studies suggest that they may serve to influence the threshold of sensory nerve endings via the release of neuropeptides (7).

The true incidence of MCC is not known. The tumor is typically found in individuals over 65 years of age. The female to male ratio is 3:1 (8). The most common sites of this tumor are head and neck (50%) and extremities (40%)(7).

Controversies exist regarding the origin of MCC. Originally, it was thought to arise from epidermal Merkel cells. Recent studies suggest that this tumor may arise from poorly differentiated epidermal stem cells, squamous cells, primitive sudoforuous cells, and melanocytes (2,3,4). It has been postulated that exposure to sun may contribute to the development of MCC (7).

Figure 2. Tumor cells show scanty cytoplasm and round nuclei with dense and uniformly distributed chomatin and small nucleoli. Mitotic activities, pyknotic nuclei and nuclear fragments are also evident.

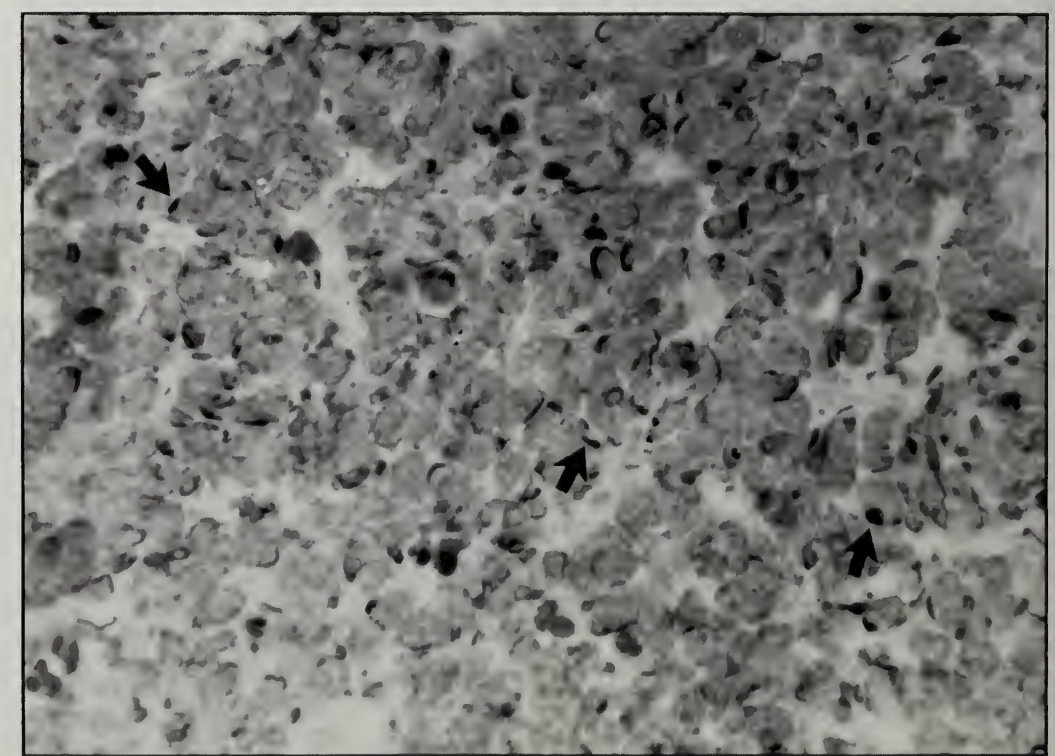

Figure 3. Tumor cells show dot-like staining (arrows) with antibodies to low molecular-weight cytokeratin (immunoperoxidase stain).

MCC is a very aggressive primary skin cancer. As in our case, metastases to regional lymph nodes are common (50%-76%)(4). MCC has a tendency to infilitrate the subcutaneous tissue and muscles and its natural history and mode of spread is similar to that of malignant melanoma (9). The tumor metastases through the blood and lymphatics to distant organs including lung, brain, bone, liver, kidney, mediastinal lymph nodes, ovary and chest wall (7,9).

The tumor can be easily confused with metastatic small cell carcinoma of bronchogenic origin, metastic neuroblastoma, malignant lymphoma, malignant melanoma, metastatic atypical carcinoid, and undifferentiated carcinoma of skin appendages. Immunoperoxidase stains are helpful in distinguishing MCC from other tumors. Typical dot-like staining with antibodies to low molecular-weight cytokeratin is characteristic (10). This feature is usually absent in small cell carcinoma of the lung or other organs (5). Cytoplasmic reactivity for NSE, chromogranin and synaptophysin, and negative staining for S-100, HMB-45 and LCA are also helpful.

MCC has a very unfavorable prognosis. Hitchcock et al have estimated a three-year survival rate of 55% (4). No five-year survival rates are available since follow-up data beyond three years has not been published. About one-third (33%) of patients develop local recurrence within one year of excision (4).

Local and regional treatment for all stages of MCC is currently recommended. Wide local excision with a wide margin of 2.5 to 3 cm is recommended for the primary lesion followed by radiation in doses of 5,000 to 6,000 cGy over four to six weeks in 20 to 25 fractions (7).

The role of adjuvant chemotherapy remains unproven because there are too few cases for a prospective clinical trial and results with a variety of other treatment protocols have been inconsistent (9).

Conclusion

A rare case of Merkel cell carcinoma of the skin is presented with review of the literature. This tumor can be easily confused with other primary and metastic tumors. Immunoperoxidase stains are very helpful for a correct diagnosis.

Due to its high mortality rate, wide local excision with adequate margin followed by radiation is the treatment of choice for MCC.

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Governor Underwood signs Medical Practice Act, attends meeting at WVSMA

On April 7, Governor Cecil H. Underwood signed into law revisions to the Medical Practice Act, which was passed by the Legislature during its regular session. This act, HB 2082, was sponsored by Speaker of the House Bob Kiss.

"The West Virginia State Medical Association lobbied very hard during the session for the passage of this bill on behalf of physicians throughout West Virginia," said WVSMA President Dr. David W. Avery. "The bill provides physicians with important due process protections in their hearings before the West Virginia Board of Medicine which will have a positive impact on patient care."

The following week, Governor Underwood was a guest at a meeting hosted by the WVSMA for Bobbie Berkowitz, Ph.D., of the Robert Wood Johnson's Turning Point Program. The WV Bureau for Public Health recently submitted proposals to Robert Wood Johnson for a grant award in the amount of $250,000 to assist with the State Public Health Transition Project.

(Top) **The signing of the Medical Practice Act by Governor Underwood was attended by Del. Sally Susman; Del. Joe Martin; Speaker of the House Bob Kiss; Dr. Alva Deardorff; WVSMA public relations and advertising director Christina Dixon; WVSMA Treasurer Dr. Betty Spangler; WVSMA Counsel Michele Grinberg; WVSMA Executive Director Evan Jenkins; and Del. Mike Damron.**
(Bottom) **Governor Underwood and First Lady Hovah Underwood are greeted at the WVSMA by WVSMA Executive Director Evan Jenkins and DHHR Secretary Joan Ohl.**

Harris Address to focus on sports medicine issues; Flink Address to discuss old, new treatment of fever

William A. Hazel, Jr., M.D., who practices general orthopaedics with a special interest in sports medicine in Herndon, Va., will present this year's Thomas L. Harris Address on Wednesday, Aug. 25 at 2:30 p.m. during the WVSMA's 132nd Annual Meeting at The Greenbrier in White Sulphur Springs. Dr. Hazel's presentation is entitled *"From Weekend Warriors to Professionals: Special Concerns Treating Athletes."*

Immediately following Dr. Hazel's lecture, **Rashida Khakoo, M.D.**, professor and chief of the Section of Infectious Diseases at the West Virginia University School of Medicine in Morgantown, will deliver the Edmund B. Flink Address on the subject of *"Fever - Old and New."*

Brief bios on Dr. Hazel and Dr. Khakoo are published below. For more details about this year's WVSMA Annual Meeting, please turn to the next page and pages 134-138, or phone the WVSMA at (304) 925-0342.

Hazel

Khakoo

Harris lecturer

Dr. Hazel is a native of Northern Virginia who received a B.S. degree in civil engineering from Princeton University in 1978. After a year of pre-med at Georgetown University, he attended Duke University School of Medicine and earned his M.D. degree. He completed his residency in orthopaedic surgery at the Mayo Clinic and then returned home to begin his practice.

Naturally interested in sports medicine as a result of his own experience with football and lacrosse injuries in high school and college, Dr. Hazel is the assistant orthopaedic surgeon for the D.C. United soccer team and served as the assistant orthopaedic surgeon for the Washington Redskins from 1988-1995.

A very active member of the Medical Society of Virginia, Dr. Hazel currently serves as speaker and is chair of the Bylaws Committtee. He is the immediate past president of the Fairfax County Medical Society and has served as chairman of the Department of Orthopaedic Surgery at Fair Oaks Hospital.

Dr. Hazel is certified by the American Board of Orthopaedic Surgery and is a Fellow of the American Academy of Orthopaedic Surgeons.

Flink lecturer

Dr. Khakoo earned her medical degree from Makerere Medical School in Uganda. She completed her residency in internal medicine at George Washington University in Washington, D.C., and then did a fellowship in infectious diseases at the University of Florida in Gainesville.

In 1976, Dr. Khakoo joined the faculty of the West Virginia University School of Medicine where she currently serves as professor and chief of the Section of Infectious Diseases. In addition, Dr. Khakoo also serves as associate chairman of the Dept. of Medicine, and is the assistant vice president for faculty development at the Robert C. Byrd Health Sciences Center.

During her career, Dr. Khakoo has received several awards for innovation and excellence in teaching, including being selected one of 25 faculty members from the United States for fellowship in the Executive Leadership in Academic Medicine Program for Women in 1995-96. She has received the Laureate Award from the WV Chapter of the American College of Physicians, and in April was appointed Governor for the WV Chapter of the ACP-American Society of Internal Medicine.

The hospital epidemiologist at Ruby Memorial Hospital, Dr. Khakoo's current research interests are in hospital epidemiology and medical education.

Please see next page & pages 134-138 for more details about WVSMA's 132nd Annual Meeting!

Medicare fraud specialist, AMA government affairs leader to present Lunch & Learn programs at Annual

"Medicare Fraud in Cyberspace" and is the title of the first Lunch & Learn program which is scheduled for noon on Thursday, August 26 during the WVSMA's Annual Meeting at The Greenbrier in White Sulphur Springs. This CME event will be presented by **Jane Wilson**, a Medicare fraud information specialist for Nationwide Mutual Insurance Company in Columbus, Ohio.

The following day at noon, the second Lunch & Learn program, *"Impacting the Legislative Process"* will be conducted by **Richard A. Deem**, vice president of government affairs for the AMA.

To register for these programs and the WVSMA's Annual Meeting, fill out the form on page 135 or phone the WVSMA at (304) 925-0342.

Wilson

Deem

Presenters highlighted

Ms. Wilson has worked with Medicare for the past 24 years. Since 1984, she has been affiliated with the Medicare Fraud Investigation Unit and is responsible for fraud awareness programs in Ohio and West Virginia, as well as establishing and maintaining a network of contacts in government and private organizations who have an interest in sharing health care fraud information.

Ms. Wilson has a B.S.B.A. degree from Franklin University in Columbus and is a member of the National Health Care Anti-Fraud Association.

Mr. Deem is a Pennsylvania native and a graduate of American University. Prior to joining the AMA in 1984, he served as special assistant to former HHS Secretary Dick Schweiker and on Schweiker's personal Senate staff.

In his role as vice president for government affairs for the AMA, Mr. Deem directs the congressional and executive branch lobbying activities in the AMA's Washington office. He represents AMA on a myriad of issues in meetings with officials on Capitol Hill, at the White House, and at the Dept. of Health and Human Services and other federal agencies.

Delegation of 11 to attend AMA Meeting

Constantino Y. Amores, M.D., will lead the WVSMA's delegation at this year's AMA Annual Meeting in Chicago from June 20-24.

In addition to Dr. Amores, the WVSMA's delegation will include AMA Delegates John D. Holloway, M.D.; James D. Helsley, M.D.; and Michael O. Fidler, M.D.; AMA Alternate Delegates W. Alva Deardorff, M.D.; James L. Comerci, M.D.; and Stephan R. Thilen, M.D.; WVSMA President David W. Avery, M.D.; WVSMA President-Elect Phillip R. Stevens, M.D.; WVSMA Council Chairman Thomas H. Chang, M.D.; and WVSMA Executive Director Evan Jenkins.

The promise continues in WV

Medical Assurance, WVSMA's endorsed professional liability carrier, maintains a strong defense commitment for all its insureds. To date, Medical Assurance has spent almost $6 million in WV in legal fees alone defending medical professionals in cases taken to trial.

Medical Assurance currently has over 980 claims pending and averages 44 new claims per month. More than $7.5 million has already been spent preparing defense for those open claims, proving Medical Assurance is committed to the defense of its insureds.

For information concerning Medical Assurance, contact Steve Brown, Michele Myers or Chuck Ellzey by calling (304) 346-8228 or (800) 331-6298.

Charleston Chapter of American Academy of Professional Coders reactivated

The Charleston Chapter of the American Academy of Professional Coders, which was originally organized in 1997, has recently been reactivated in an effort to reach out to interested individuals in the southern half of the state. Two other chapters currently exist in Elkins and Morgantown.

Activities of the chapters of the AAPC are designed to promote the establishment and maintenance of professional, ethical and educational standards for medical billing and coding personnel. These chapters seek to optimize reimbursement by maintaining good relations with representatives from the reimbursement community, as well as the colleagues in like specialty practices.

In addition to bi-monthly meetings, the Charleston Chapter has at least two study groups that are loosely affiliated with the group, which teach new employees correct coding and helps to prepare them for the CPC examination if they wish to take it.

The Charleston Chapter officers are President Rebecca Clendenen, CPC, (388-1569); President-Elect Shirley Gainer, CPC (927-6396); Secretary Dawn Webb, CPC (388-1534); and Treasurer Wanda Marple, CPC, (388-1509).

Interested individuals are invited to attend the next meeting on June 16 at 8:30 a.m. in the auditorium at the WVU Building on the campus of CAMC, Memorial Division, or phone one of the officers.

First certification exam for wound management offered

Over a thousand wound care professionals have gained or are in the process of gaining board certification from the American Academy of Wound Management via completion and review of a portfolio of materials documenting experience and training in wound management. This portfolio method of attaining board certification will end on June 30.

After June 30, board certification in wound management can only be achieved by a passing score on the board certification exam. The first exam has been scheduled for Oct. 4, 1999, during the 14th Annual Clinical Symposium on Wound Care in Denver. The exam will be relevant to all health professionals involved in wound care, including, but not limited to, physicians, nurses and therapists.

For more information, contact Mike Freedman at (305) 866-9592.

Medical Meetings

July

6-11 - Intensive Review Course of Pediatric Infectious Diseases, Chicago

18-21 - Eighth National Alzheimer's Disease Education Conference, Long Beach, Calif.

16-18 - American Society of Addiction Medicine Medical Review Officer Training Course, Washington, D.C.

August

16-20 - Medical Informatics Introductory Short Course, San Diego

23-27 - Society of Computed Body Tomography and Magnetic Resonance Summer Practicum, Keystone, Colo.

September

1-4 - American Society for Surgery of the Hand, Boston

1-4 - Surfaces in Biomaterials '99, Scottsdale, Ariz.

2-4 - Acad. of Surgical Research's 15th Annual Meeting, Scottsdale, Ariz.

24-29- American College of Radiology Annual Meeting, Washington, D.C

October

1-3 - American College of Nutrition Annual Meeting, Washington, D.C.

8-10 - International Workshop on Langerans Cells, New York, NY

9-13 - American Academy of Pediatrics, Washington, D.C.

15-17 - Current Practice of Vascular Ultrasound, Washington, D.C.

November

1-2 - National Association of Physicians for the Environment, Bethesda, Md.

132nd Annual Meeting Preliminary Program

Tuesday August 24

6 p.m. WVSMA Executive Committee Dinner/Business Meeting

Wednesday, August 25

9 a.m. WVSMA Council Meeting
11:30 a.m. Executive Committee/Council - Component Society and Specialty Society Presidents' Luncheon
1:30-4:30 p.m. **First Session House of Delegates, Governor's Hall**
1999 WVSMA Award Presentations, Thomas L. Harris Address, Edmund B. Flink Address, Constitution and Bylaws, Annoucement of 1999-2000 Candidates for Office, Introduction of Resolutions
WVSMA Presidential Address, *"Follow the Yellow Brick Road"* David W. Avery, M.D., WVSMA President

6:30-7:30 p.m. Presidential Reception

Thursday, August 26

7 - 8:30 a.m. Medical Education Committee Breakfast Meeting
8:30 - Noon **FIRST GENERAL SESSION**
"Change and Readiness to Change" Joseph B. Selby, MD
"New Approaches in the Management of Diabetic Foot Ulcers" Rhonda Lee Travaglino Parda, MD
"Communication and Disease Management" Steven A. Smith, MD, Mayo Clinic
"What Goes Around Comes Around: Public Health 1900-2000" Henry G. Taylor, MD, MPH, Bureau of Public Health

Noon-1:30p.m. **Lunch & Learn,** *"Medicare Fraud in Cyberspace"* Jane Wilson, Medicare Fraud Information Specialist, Nationwide Insurance

1:30 p.m. Committee on Resolutions
2 p.m. Golf, Tennis, and Volleyball Tournaments
4:30-5:30 p.m. WESPAC Meeting
6:30-7:30 p.m. Reception, *Hosted by Medical Assurance of WV and Acordia of WV*

Friday, August 27

7 a.m. Breakfast Meetings - Times and Locations TBA
8:30 - 9 a.m. WVSMA *Alliance* Registration
8:30-4:30 p.m. WVSMA Registration, Exhibit Center Foyer

9 - Noon **SECOND GENERAL SESSION**
"Radiology Update"
"Cardiac News", William E. Noble, MD, FACC
"Responding to Bio-Terrorism," LTC Ted Cieslak, MD
"Interventional Bronchology: Newer Procedures in the Diagnosis and Treatment of Lung Cancer" Francis Lee, MD, FCCP

Noon-1:30 p.m. **Lunch & Learn,** *"Impacting the Legislative Process,"* Richard Deem, Vice President for Government Affairs, AMA

Noon Specialty Meetings - Times and locations TBA
Noon WVSMA *Alliance* Board Luncheon
2-4 p.m. *"Your Practice: Prescription for the Future,"* Medical Assurance Loss Control Seminar, Eisenhower A
4:30-5:30 p.m. Scientific & Educational Sessions Committee
6 - 7 p.m. Reception, *Hosted by West Virginia University and Marshall University Schools of Medicine*
9 - Midnight *"Louisiana's Rockin' Fiddler" and Band,* Waylon Thibodeaux

Saturday, August 28

7:30 a.m. Breakfast Meetings - Times and Locations TBA
8 a.m. WVSMA *Alliance* Past President's Breakfast

8 - 9 a.m. Delegate Voting and Registration
9:15 a.m. **WVSMA Second Session House of Delegates**
AMA Presidential Address, Business Meeting, Resolutions, Announcement of Election Results

Noon-1:30 p.m. WVSMA Past Presidents, Visiting State Presidents and 50-Year Graduates Luncheon

1:30 p.m. **Reconvene Second Session of the House of Delegates**
Oath of Office
Presidential Address - *"Healthcare in the '90s, The Gathering Storm"* Phillip R. Stevens, MD
Adjournment

- An AMA Delegation Meeting in WVSMA Suite #6613 will follow the 2nd Session of the House of Delegates.

TBA Reception Honoring Newly Installed Officers of WVSMA and Alliance

The West Virginia State Medical Association

132nd Annual Meeting

August 25-28, 1999

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Registration Form

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Register online at www.wvsma.com. Click on "upcoming meetings"!!

Fax us your registration form at (304) 925-0345.

Registration Fees — Before August 1, 1999 (Early Bird)

❒ **WVSMA Member**	**$115**
❒ **Non-member**	**$165**

Registration Fees — After August 1, 1999

❒ **WVSMA Member**	**$125**
❒ **Non-member**	**$175**

Lunch & Learn — Thursday, August 26, 1999
"Evaluation & Management Guidelines for Fraud and Abuse"

❒ **WVSMA Member** (With CME)	**$50 (each session)**
❒ **All others** (No CME credit)	**$35 (each session)**

Lunch & Learn — Friday, August 27, 1999
"Impacting the Legislative Process"

❒ **WVSMA Member** (With CME)	**$50 (each session)**
❒ **All others** (No CME credit)	**$35 (each session)**

Payment by: ❒ Check ❒ MasterCard ❒ VISA

Total Due: _____

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Cancellation of registration should be in writing. If a cancellation is postmarked or phoned to the WVSMA before August 1, 1999, the paid registration fee will be refunded less a $50 administrative charge. For cancellations after August 1, 1999, no refunds will be made.

Lunch & Learn at WVSMA's Annual Meeting, Thursday, August 26 and Friday, August 27.

"Evaluation and Management Guidelines for Fraud and Abuse"
Jane Wilson, Medicare Fraud Information Specialist
Thursday, August 26
Noon - 1:30 p.m.

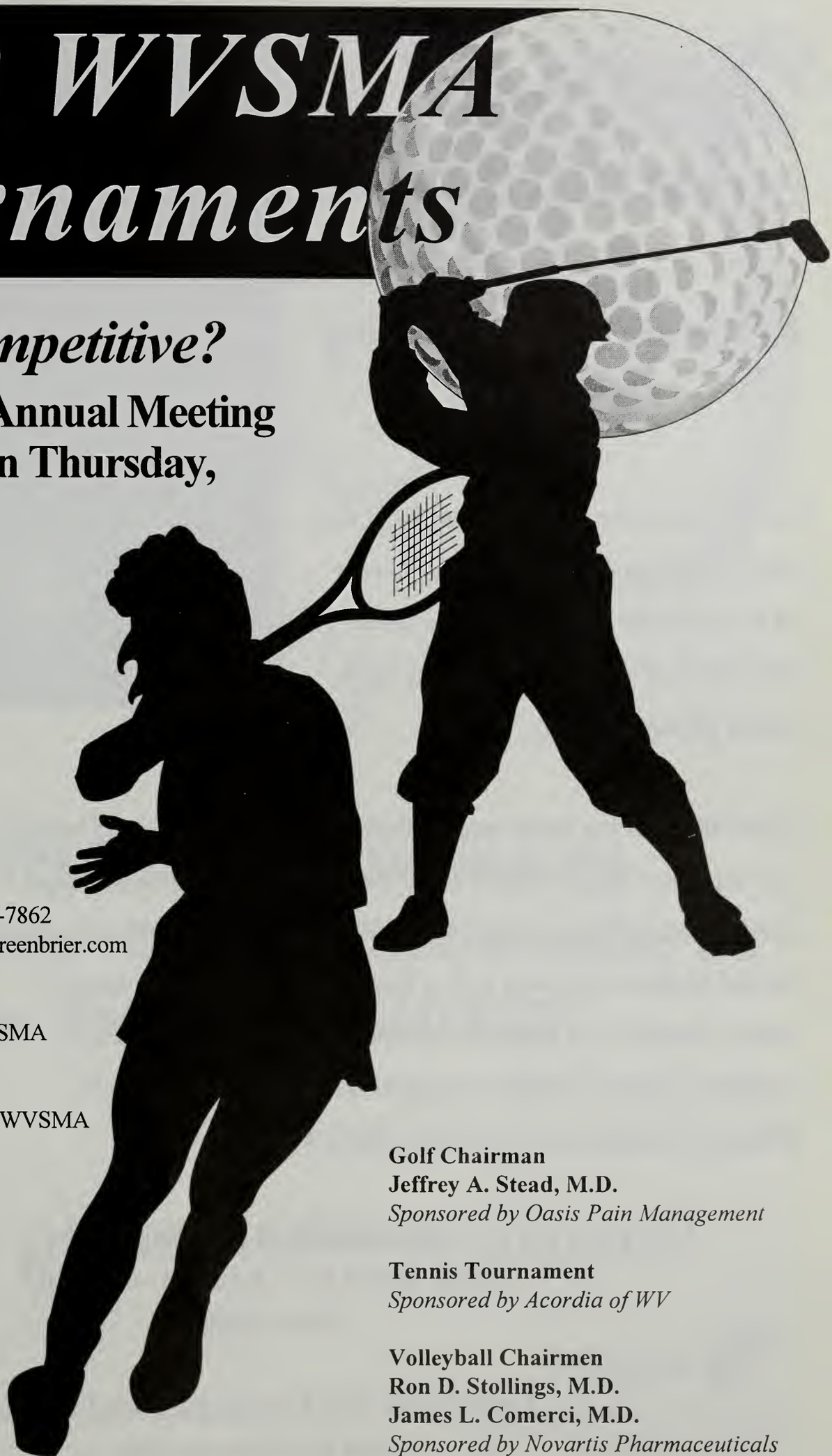
Join us in August

"Impacting the Legislative Process"
Ms. Tracy Sinnott, American Medial Political Action Committee (AMPAC)
Friday, August 27
Noon - 1:30 p.m.

26th

27th

1999 WVSMA Tournaments



Feeling Competitive?

Join us for the Annual Meeting Tournaments on Thursday, August 26!

To Register for:

- **Golf** Please call (304) 536-7862 or e-mail JohannaHonaker@greenbrier.com for golf starting times.
- **Tennis** Sign up at the WVSMA Registration Desk
- **Volleyball** Sign up at the WVSMA Registration Desk

Golf Chairman
Jeffrey A. Stead, M.D.
Sponsored by Oasis Pain Management

Tennis Tournament
Sponsored by Acordia of WV

Volleyball Chairmen
Ron D. Stollings, M.D.
James L. Comerci, M.D.
Sponsored by Novartis Pharmaceuticals

WAYLON THIBODEAUX

"Louisiana's Rockin' Fiddler"

Celebrate Annual Meeting

Cajun Style

Don't miss out on the music, food, and fun at this year's Annual Meeting. The Chesapeake Room at The Greenbrier will be the setting for a special casual evening of entertainment featuring Cajun musician Waylon Thibodeaux.

Waylon Thibodeaux is a french-speaking Cajun, who performs a variety of Louisana, Cajun and Zydeco music. Known as *Lousiana's Rockin' Fiddler*, Thibodeaux began playing professionally at age 13 and has performed with nationally and internationally renowned musicians and groups such as Tony Orlando, Jo-El Sonnier, Jimmy C. Newman, BeauSoleil and Evangeline, and an artist with Mardi Gras Records. In addition to playing at festivals and special events in the U.S. and Canada, Thibodeaux is a popular act at La Strada's Nightclub in New Orleans.

Chesapeake Room, The Greenbrier
Friday, August 27 • 8:30 p.m. - Midnight
Casual Attire

Entertainment hosted by Acordia of West Virginia
A cash bar will be available

Mid-Winter Clinical Conference

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CME & Special Events

Camcare Health Education & Research Institute

"High Risk Obstetrics and Perinatal Care"
June 7, 5:45 p.m., Stefan Maxwell, M.D., and Wayne Conover, M.D., Cafe Acropolis, Summersville

"Issues in Medical Ethics"
June 9, 8 a.m., Robert T. Hall, Ph.D., Tamarack, Beckley

"Common Respiratory Problems"
June 10, 5:45 p.m., Loay Al-Asadi, M.D., Twin Falls State Park, Mullens

"Geriatric Trauma"
June 16, 6 p.m., Frank Lucente, M.D., Man ARH, Man

"Bee Stings and Allergic Reactions"
July 9, noon, Nasim Sheikh, M.D., Logan General Hospital, Logan

"Acute Pain Management"
July 13, 5:45 p.m., Ray D'Amours, M.D., Tamarack, Beckley

"Prevention of Severe Chemotherapy Induced Thrombocytopenia"
July 19, noon, Randi Isaaacs, M.D., Robert C. Byrd HSC of WVU, Charleston

"Acute and Chronic Renal Failure"
July 21, 6 p.m., Robert Vaughn Lamb, M.D., Man ARH, Man

"Diagnosis and Treatment of Congestive Heart Failure"
Aug. 2, 5:45 p.m., William Carter, M.D., Sycamore Creek Golf Club, Ripley

"Lacrosse Encephalitis"
Aug. 4, 12:30 p.m., James McJunkin, M.D., Montgomery General Hospital, Montgomery

Huntington Medical Community Foundation

"Head Trauma"
June 21, 6 p.m., Speaker TBA, Three Rivers Medical Center, Louisa, Ky.

"Naturopathic Medicine"
June 24, noon, Darrell Samples, N.D.O.M.D., Pleasant Valley Hospital, Point Pleasant

"An Overview of Interventional Radiology"
June 24, 6:30 p.m., Paul Capito, M.D., Ashland Plaza Hotel, Ironton, Ohio

Marshall University School of Medicine

"Faculty & Professional Development Series: Part 1 - New Models of Delivering Education - Web Based Seminars"
June 18, noon, Gerald Kelliher, Ph.D., MU Medical Center Auditorium, Huntington

"Faculty & Professional Development Series: Part 2 - Presentation Skills for Effective Teaching"
June 19, 8:15 a.m., John Szarek, Ph.D., Gerald Kelliher, Ph.D., Sarah McCarty, M.D., and Hyla Harvey, M.D., Medical Education Building, VA Medical Center, Huntington

"MU School of Medicine Alumni Weekend Conference"
Sept. 24, MU Medical Center & Radisson Hotel, Huntington

"Annual Cancer Conference"
Oct. 1, St. Mary's Hospital, Huntington

Robert C. Byrd HSC - Morgantown

"Domestic Violence"
June 10, Mary Ann Sens, M.D., Ph.D., Broaddus Hospital, Philippi

"A Summit to Improve End-of-Life Care in West Virginia"
June 18, Days Inn Conference Center, Flatwoods

"Update on AIDS"
July 8, 1 p.m., Wesley Farr, M.D., Broaddus Hospital, Philippi

"Congestive Heart Failure"
July 8, noon, Anurag Mehta, M.D., Wetzel County Hospital, New Martinsville

"Cardiology Conference"
July 10, Robert C. Byrd HSC, Morgantown

"Advanced Life Support in Obstetrics (ALSO)"
July 23-25, Canaan Valley Resort & Conference Cnt., Davis

"Colon Cancer and Endoscopic Ultrasound"
July 26, 4 p.m., The Greenbrier Clinic, Lisa Gangarosa, M.D.

"Developing Competencies in Palliative Care"
July 28-31, Canaan Valley Resort & Conference Cnt., Davis

West Virginia State Medical Association

"WVSMA's Annual Meeting"
Aug. 25-28, The Greenbrier, White Sulphur Springs

The Old Woman's Song

The days prolong
The cold is gone
And I can hear
The old woman's song

Spring is near
Her song on ear
Place old pot there
Plase new pot here

Old clothes she wears
Her gnarled hands bare
A bonnet shades
The sun's bright glare

She stoops and spades
The little blades
Of grass and weeds
Out of the way

She plants her seeds
And prays no freeze
For daffodil dear
And anemone

Then the little boy
And girl at play
Stop and talk
Full life today

They laugh and sing
Dancing around her in rings
When an old life ends
A new one begins

And I can hear
The old woman's song
To live one more year
For the children's song

P. V. Swearingen, M.D.

Osteoporosis a critical problem in West Virginia

Osteoporosis is reaching epidemic proportions in the elderly population. Currently, an estimated 10 million Americans suffer from osteoporosis and another 18 million have low bone mass.

In 1996, the Mountain State had the oldest population in the nation, and ranked fourth in the U.S. in the proportion of its population that is elderly (65+). For that same year, the Office of Epidemiology and Health Promotion at the West Virginia Bureau for Public Health reported that a total of 183,962 women ages 50+ and 39,696 men ages 50+ suffered from either low bone mass or osteoporosis. At this rate, the National Osteoporosis Foundation has projected that a total of 270,629 women and men in West Virginia will have osteoporosis or low bone mass by the year 2015.

Fortunately, there is much that the health care community can do to prevent this disease in individuals at risk and to diagnose and treat osteoporosis in those already affected. The National Osteoporosis Foundation has indicated that education and early detection can help control osteoporosis in the United States. To achieve this goal, though, both physicians and patients must be much better educated about prevention and the benefits of testing for osteoporosis.

Due to the severity of the problem in West Virginia, Chapter 16 of the West Virginia State Code was amended during the 1996 West Virginia Legislative session to create the ***West Virginia Osteoporosis Act***. This legislation provided for the establishment of the West Virginia Osteoporosis Prevention Education Program, designed to provide awareness and educational opportunities for the public and health professionals.

In response to a demonstrated need for early intervention and clear practice guidelines for physicians, the National Osteoporosis Foundation issued specific recommendations for managing and preventing osteoporosis which are published in ***The Physician's Guide to Prevention and Treatment of Osteoporosis.*** This publication includes specific guidelines on the use of bone mineral density tests, the single most reliable tool for assessing bone strength and osteoporosis risk. It was developed by the National Osteoporosis Foundation in collaboration with 10 multidisciplinary medical organizations. The guide also includes specific recommendations for Caucasian women, who are at highest risk for the disease.

The Physician's Guide specifies that women who are 65 and older should have a bone density test, regardless of other risk factors such as postmenopausal women who have one or more risk factors for osteoporotic fracture (besides menopause), and all postmenopausal women who have had a fracture. The recommendations also specify that all postmenopausal women with vertebral or hip fractures, two of the most common osteoporosis fracture sites, should be considered candidates for osteoporosis treatment. Now, with the implementation of the ***Bone Mass Measurement Standardization Act***, which standardizes coverage of bone mass measurement tests for Medicare beneficiaries, no woman 65 or older should go untested.

"Bone density tests are now widely available and should be offered to all women to detect low bone density before their bones are weakened and fracture occurs," says Dr. Henry G. Taylor, the commissioner of the West Virginia Bureau for Public Health.

"Osteoporosis is a 'silent' risk factor for fracture. Prevention, detection and treatment of osteoporosis should be a mandate of primary care, and a routine part of physicals."

According to Dr. Taylor, osteoporosis is under-diagnosed among postmenopausal women, and that many women are developing osteoporosis without the disease being recognized and treated. "With rapid advances in diagnostic technology and osteoporosis therapies, we feel there is a gap between the science and current clinical practice. This physicians guide will help practionitioners assess weather women without overt symptoms are developing this disease. We have only recently accumulated enough data for the National Osteoporosis Foundation to provide physicians with clear recommendations for using the new technologies and therapies.

"When cholesterol tests first came out, it wasn't clear what the 'normal' range was, or when you should begin treatment. The same has been true for osteoporosis and bone density tests," explained Dr. Taylor. "But now we have the data, and a guide that specifically addresses the interpretation of bone density tests, how to apply the results in clinical practice, and when to use these tests. If detected early, therapies can be started to prevent or minimize the disease."

If you are interested in obtaining a copy of ***The Burden of Osteoporosis in West Virginia*** and/or ***The Physician's Guide to Prevention and Treatment of Osteoporosis***, contact the West Virginia Bureau for Public Health, Osteoporosis Prevention Education Program at (304) 558-0644.

Kim Smith, M.S., C.H.E.S..
West Virginia Bureau for Public Health

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Robert C. Byrd Health Sciences Center of West Virginia University News

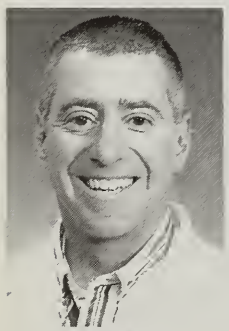
Lung cancer program unique to West Virginia

WVU's Comprehensive Lung Cancer Program is the only program in the state to bring together specialists from pulmonary medicine, cardiothoracic surgery, medical oncology, radiation oncology, and diagnostic radiology to provide comprehensive services and expedited invasive and non-invasive procedures for the diagnosis and treatment of lung cancer.

Part of the Mary Babb Randolph Cancer Center, the clinic is a joint program of the Dept. of Surgery and the Dept. of Critical Care Medicine and Hematology/Oncology. Coordinators include Dr. Geoffrey Graeber, Cardiothoracic Surgery; Dr. John S. Rogers II, Hematology/Oncology; Dr. Daniel E. Banks, Pulmonary Medicine; Dr. Naresh Gupta and Dr. Janis Hurst, Radiology.

Patients may be referred at any stage of their disease.

Fidler receives award as outstanding teacher



Fidler

Dr. Donald Fidler of behavioral medicine and psychiatry has received one of six 1999 WVU Foundation Outstanding Teacher Awards.

Dr. Fidler, also an instructor in the Division of Theatre, has used his experience in theater, film and video to produce more than 50 medical education videos using actors and film techniques to dramatize psychiatric and ethical issues.

Birkle wins WVU's Buswell award

Birkle

Dr. Dale Birkle, an associate professor in pharmacology and toxicology, has won WVU's 1999 Mary Catherine Buswell Award for Outstanding Service to Women.

Dr. Birkle has worked to significantly increase the math and science opportunities for West Virginia women and girls. She was a founding member of the WV Chapter of the Association for Women in Science, an organization that includes more than 300 scientists, engineers, mathematicians and supporters who work to promote opportunities in science and math for West Virginia women and girls. She served for six years as treasurer and is currently the association's president.

New drug combo helps treat Hepatitis C

A new combination treatment of the antiviral ribavirin and the immune modulator interferon presents a good chance to fully recover from HCV, a prominent cause of liver disease, said Dr. John Shamma'a, gastroenterology.

WVU welcomes candidates and requires that patients undergo a pretreatment screening before the combination treatment is prescribed. Recent trials suggest that about 40 percent of patients who complete the combination treatment fully surpress the virus and normalize blood tests. This percentage is much higher than those of patients who receive single treatments of ribavirin or interferon.

The combination treatment of ribavirin and interferon is long-term and somewhat intensive. Self-injections of interferon and daily tablets of ribavirin are required, and the treatment takes from six months to a year. Patients undergoing the treatment should be checked frequently because the potential for side effects is relatively high.

Match successful for 97 percent of seniors

In the 1999 residency match of 13,707 U.S. medical school seniors, 97 percent of the graduating class of the WVU School of Medicine were accepted into one of their top three choices for postgraduate training programs. Nationally, 80.5 percent of U.S. seniors matched to one of their first three choices.

The Class of 1999 will have 82 graduates, 80 of whom participated in the national residency matching program. (Four are December 1998 graduates.) Of these, 18 chose internal medicine, 17 chose family medicine, six will study pediatrics, five will combine internal medicine and pediatrics, and two will study obstetrics and gynecology.

In total, 48, or 60 percent, are entering primary care studies. The remaining grads will train in specialty programs. The most popular specialty areas include internal medicine programs which are preliminary to further specialization, surgery, and emergency medicine.

About half of this year's WVU grads will enter residency programs in West Virginia.

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Marshall University School of Medicine News

Expanded pediatric cardiac surgery available in Huntington

Dr. Dennis M. Moritz, a pediatric and adult cardiovascular and thoracic surgeon, has joined the Marshall University School of Medicine faculty. Dr. Moritz, a U.S. Army colonel, previously had been chief of cardiothoracic surgery at Walter Reed Army Medical Center.

"Dr. Moritz's presence brings a renewed interest in pediatric cardiac surgery to Huntington," said Dr. J.D. Harrah, chair of Marshall's Department of Cardiovascular Services. "We are pleased to be able to make his expertise available to the people of our region."

Dr. Moritz is a graduate of the U.S. Naval Academy, the U.S. Naval Postgraduate School, and the University of Illinois College of Medicine. He did his internship and residency in general surgery at Walter Reed, his residency in cardiothoracic surgery at the University of Illinois at Chicago, and his fellowship in pediatric cardiac surgery at the University of Alabama at Birmingham.

Prior to coming to MU, Dr. Moritz was a consultant to the surgeon general of the Army for thoracic and cardiovascular surgery. He also was chair of the National Capital Area Cardiothoracic Committee. At Walter Reed, he was program director for the cardiothoracic surgery residency program, chair of the Operating Room Committee, and a member of the Critical Care Committee.

A fellow of the American College of Surgeons, the American College of Cardiology, and the American College of Chest Physicians, Dr. Moritz is also a member of many other professional organizations including the Society of Thoracic Surgeons and the American Heart Association's Member Council on Cardiothoracic and Vascular Surgery.

MU graduates again top national average in family practice

MU School of Medicine graduates will enter family practice residencies at a rate 73 percent above the national average, according to results released today by the National Resident Matching Program.

Of the 47-member graduating class, 12 students will enter family practice residencies -- a rate of 26 percent, compared to 15 percent nationally. Overall, 51 percent of MU graduates will enter residencies in the primary care fields of family practice, internal medicine, pediatrics, and obstetrics and gynecology, according to Dr. Patrick I. Brown, associate dean for academic and student affairs.

Students, faculty honored

More than a dozen graduating medical students were presented awards in commencement-related ceremonies for the MU School of Medicine, with four faculty awards being presented as well.

Tied for the Bertha and Lake Polan Award, given to the student(s) with the highest academic rank, were **Adam M. Franks** of Huntington, **Devin A. King** of Independence, and **Bryan D. Springer** of Stevensville, Md. **Springer** also received the MUSOM Alumni Association Recognition Award, which honors the graduate whom faculty members feel best exemplifies the highest attributes of physicianhood. **Franks** received the W. Edwin Black Award for rural health.

The Ciba-Geigy award, which goes to the student whose colleagues feel epitomizes the ideal physician, went to **Eric C. Jones** of Charleston.

Recipients of specialty-specific awards were:

Steven S. Brumfield of Huntington, the Lloyd F. Zacharias Award (OB/GYN);

Donna M. Bolden of Huntington, the Thomas G. Folsom Award (pediatrics);

Robert B. Gray of Hattiesburg, Miss., the Excellence in Emergency Medicine Award;

Christine K. Kim of Morgantown, the Fuller Albright Award, who was also awarded the Janet M. Glasgow Memorial Award as the top female graduate;

Indira D. Gautam of Morgantown, the Gastroenterology Award; and

Nancy B. Norton of Huntington, the Dr. Maurice A. and Diane W. Mufson Award (internal medicine), who also received a Janet M. Glasgow Citation

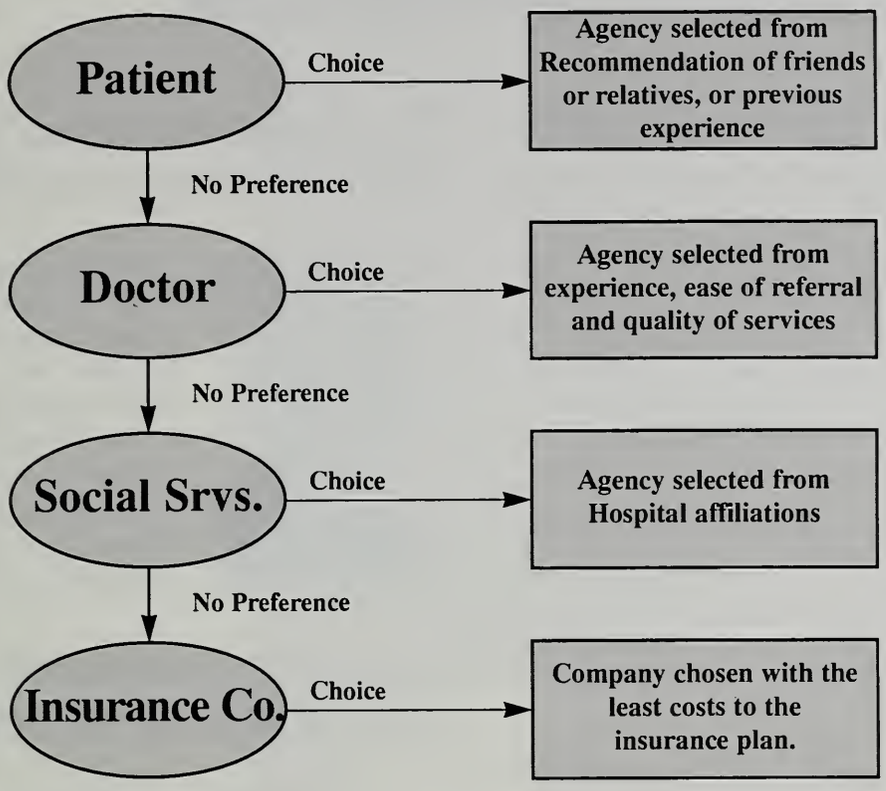
Lora J. Jobe of Huntington, a Janet M. Glasgow Citation

Patrick A. Stone of Bancroft, the WVRHEP Outstanding Community Service Project.

Larry D. Dial, Jr., of Barboursville received the Healthcare Foundation of New Jersey Humanism in Medicine Award.

Faculty receiving honors included **Dr. Ted Solari** of Beckley, who was presented the 1999 Rural Clinical Preceptor Recognition Award; **Dr. P. Mitchell Charles** was named Attending Physician of the Year; and **Dr. Danielle King** was named Resident of the Year. In addition, **Pediatric Cardiology** was named the outstanding clinical department.

Healthcare — Who's Choice is it?



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West Virginia School of Osteopathic Medicine News

WVSOM ranked in top 50 U.S. primary care medical schools

The West Virginia School of Osteopathic Medicine has been ranked in the top 50 primary care medical schools in the nation by *U.S. News & World Report.*

The school is ranked #27 nationwide in the *"U.S. News Best Graduate Schools Year 2000 Edition"* magazine (March 29 edition) and guidebook (April 6 edition).

"This is just a great, great honor," says WVSOM President Olen E. Jones, Jr., Ph.D. "What is so gratifying is the fact that this ranking meshes perfectly with our stated mission of providing family practice and primary care physicians for West Virginia and Appalachia."

WVSOM was the top ranking osteopathic school in the list. WVSOM also was the top medical school in the category of "percent of physicians entering primary care."

Stookey honored at national meeting

James Stookey, D.O., vice president of osteopathic medicine and dean of the WVSOM, was presented the prestigious "Andrew Taylor Still Medallion of Honor" at the annual convention of the American Academy of Osteopathy (AAO) in St. Louis.

This medallion is the highest award confered by the AAO.

Five students named to SOMA board posts

Five WVSOM students have been appointed to positions on the national Student Osteopathic Medical Association (SOMA).

Students appointed included Tatiana Konchesky of Elkins, who will serve as International Health Program Director; Tammy McVay of Martinsburg, who was appointed Domestic Violence Awareness ChairPerson; Wendy Neal of Bluefield, who was appointed Foundation Chairperson; David Prisk of Huntington, who was named Student Doctor Associate Editor/Advertising Manager; and Craig Warren of Pontotoc, Miss., who was appointed OP & P Director.

These students were chosen from all 19 osteopathic schools nationwide to represent SOMA in the mentioned areas for the 1999-2000 term.

National Osteopathic Unity Day celebrated

The WVSOM joined with the other 19 osteopathic schools across the nation in celebrating National Osteopathic Unity Day on March 24.

At WVSOM, faculty, staff and students gathered for breakfast and then signed a banner demonstrating their support for the ideas behind National Osteopathic Unity Day. This event was created and is promoted by the American Osteopathic Association, which recently passed six resolutions designed to achieve the goals of raising public awareness of osteopathic medicine in the local community and across the nation; accentuating osteopathy's distinctiveness; and unifying the various organizations that represent the profession.

Dr. Mugaas named to Rehabilitation Council

John Mugaas, Ph.D., professor of physiology at WVSOM, has been named to the West Virginia State Rehabilitation Advisory Council. His term will run until June 30, 2001.

American Indians of WV hosted by WVSOM

American Indians representing the several different Appalachian tribes of West Virginia visited the WVSOM on April 8 as the school hosted "American Indian Day."

Events included drums and sacred tribal dancing as well as a demonstrations on Indian crafts.

New member elected to WVSOM Foundation

Donald Sandoval, CEO of Greenbrier Valley Medical Center, has been elected to the board of directors of the WVSOM Foundation, Inc. He will serve until 2002.

Memorial service held for human gift donors

Faculty, staff and students from the WVSOM gathered at Rosewood Cementary recently to pay respects to those who have donated their bodies to medical science.

Family members of the deceased were thanked by anatomy professors and first-year students.

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Alliances making a difference in state, nation

As I write this article, our country has just been through another act of school violence. We are all touched by this senseless killing of innocent children and a teacher. We are confused and worried that the same thing could hapen to our children.

Ann Hansen, president-elect of the AMA Alliance has just announced her goals for the coming year. Her top priority is the SAVE program (Stop America's Violence Everywhere). As a part of this program, the Alliance will focus on SAVE-A-SCHOOL during the coming year. This program will attempt to address some of the problems facing our children in the schools today and to make schools as safe as possible for all children and teachers. At the Mid-Atlantic Regional Confluence in March, Ms. Hansen brought the challenge to each of us to join in this project. In turn, I ask each of you, as physicians, to make sure that you and your spouse are both actively involved. Please help SAVE-A-SCHOOL.

On a more positive note, I am proud to report that West Virginia's medical schools will be receiving $29,000 in AMA Foundation funds this year. More than half of that amount has been raised by Alliance projects. Our state chairs, Michelle Latos and Lynn Comerci, along with all the county Alliance chairs deserve a pat on the back for all of their fund-raising efforts.

I am pleased to announce that we will be attending the AMA convention in June with an additional delegate. Our membership numbers have increased this year and we have regained the delegate we lost last year. Our immediate past president, Kathy Fortunato, will represent West Virginia as a member of the AMA Alliance Health Projects Committee for 1999-2000, and as a member of the Ohio County Medical Alliance which will be honored with a HAP (Health Awareness Promotion) Award at the convention. The Ohio County Medical Alliance received a perfect score for their project called START — Start Today and Recognize Tomorrow, which will be held over a five-year period to help people live healthier lifestyles. START is being conducted with the Ohio County Medical Society, as well as area hospitals, physicians, public service agencies, and public health agencies. This program began with a free aerobic concert presented by Richard Simmons on Sunday, November 8 at the Wheeling Civic Center. Over 950 exercised with Richard that day! The START program in Ohio County is seen as a pilot project, and the Ohio County Medical Alliance hopes that the program will eventually be adopted thoughout the region, state and nation. Congratulations Ohio County!

It has been an exciting year for the WVSMAA. As the year starts to wind down, I am looking forward to our 75th anniversary convention at The Greenbrier. Please join us in our celebration by encouraging your spouse to join the Alliance today.

Jerrry Crites
President, WVSMA Alliance

New Members

We are pleased to welcome the following new members to the WVSMA:

Physicians

Krishan Aggarwal, MD
Weirton, WV

Madhu Aggarwal, MD
Weirton, WV

James G. Cain, MD
Morgantown, WV

Toni Goodykoontz, MD
Morgantown, WV

John D. Justice, MD
Morgantown, WV

Niti Armistead, MD
Morgantown, WV

Reyaz Haque, MD
Morgantown, WV

Gerardo Lopez, MD
Morgantown, WV

Shanthi Manivannan, MD
Morgantown, WV

Anurag Mehta, MD
Morgantown, WV

Paul Ogershok, MD
Morgantown, WV

John E. Parker, MD
Morgantown, WV

Brita Boyd, MD
Morgantown, WV

Geoffrey Bradford, MD
Morgantown, WV

J. David Garnett, MD
Morgantown, WV

Atiya Khan, MD
Morgantown WV

Matthew Lively, MD
Morgantown, WV

Kathryn Moffett, MD
Morgantown, WV

Robert J. Steelman, MD
Morgantown, WV

Danielle Tran, MD
Morgantown, WV

Jill Justice, MD
Morgantown, WV

Peter Ehrlich, MD
Morgantown, WV

Peter Mucha, MD
Morgantown, WV

Stephen P. Povoski, MD
Morgantown, WV

George A. Cortas, MD
Williamson, WV

Janak P. Patel, MD
Parkersburg, WV

Martha J. Gelderman, DO
Union, WV

Mark E. Promersberger, MD
Martinsburg, WV

Lisa J. McGonigal, MD
Wheeling, WV

E. Jean Salon, MD
Beckley, WV

Phillip Murray, MD
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Joseph C. Capito, MD
Wheeling, WV

Scott R. Gibbs, MD
Huntington, WV

Cathy A. Dailey, DO
Parkersburg, WV

Thomas Herrman, MD
Parkersburg, WV

John L. DeFilippo, MD
Wheeling, WV

Houman H. Khosrovi, MD
Parkersburg, WV

JoAnn Allen, MD
Morgantown, WV

WESPAC News

We would like to thank the following individuals for their recent contributions to the WESPAC Fund:

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Obituaries

Robert C. Bock, M.D.

Dr. Robert Courtney Bock, 84, of Charleston, died April 16 in Memorial Division, CAMC, from complications from heart surgery.

Dr. Bock was born in Charleston. He attended Charleston High School and West Virginia University, and received his medical degree from the University of Louisville Medical School in 1938. He did his internship and residency at Louisville City Hospital.

An Army veteran of World War II, Dr. Bock was a surgeon with the Army 8th Air Corps, who attained the rank of major. After returning from the service, he established a private practice in Charleston, where he cared for patients for 39 years. Following his retirement in 1984, he worked for the State of West Virginia in both the Social Security and Health and Human Resources Departments.

Dr. Bock was president of the medical staff and a member of the board of directors at Mountain State Hospital, and later at St. Francis Hospital. He was a member of the surgical staffs at St. Francis, Mountain State Memorial, McMillan, Thomas Memorial, Kanawha Valley, and General and Memorial Divisions of CAMC. He assisted with the Cancer Clinic at both Mountain State and Charleston Memorial Hospital.

During his career, Dr. Bock was a physician for the Charleston High School football and wrestling teams with 20 years' service, and for George Washington High School with 10 years' service. He was a volunteer at Stonewall Jackson High School and Marmet Junior High, and was honored for his participation in the West Virginia high school track and field events, as well as his work with the Golden Gloves amateur boxing tournaments.

Dr. Bock had been a member of the WVSMA since 1946 and was a 50-year member of the AMA. He was also a current member and past president of Kanawha Medical Society

Surviving: wife, Margaret Bock; sons, Steve of Charleston, Dave of Lakewood, Colo.; Jerry of San Francisco; daughter, Barry McCullough of Austin, Texas; and six grandchildren.

A "Celebration of Life" Memorial Service will be held for Dr. Bock on June 7 at the Riverside Pavilion at Coonskin Park from 5 p.m. until dusk. Anyone that wishes wishes my express their memories at the gathering.

Robert A. Crawford, Jr., M.D., F.A.C.S.

Robert Alexander Crawford, Jr., M.D., F.A.C.S., 79, a former general surgeon in Charleston and City Council majority leader, died April 4 in Huntersville (N.C.) Oaks Nursing Home after a long illness.

"He was a fine gentleman," remembers longtime Councilman Howard Quick who served on the Charleston City Council with Dr. Crawford under Mayor John Hutchinson. "He was instrumental in helping get things done. He was one of the best council members I've served with."

Former Mayor Kent Hall said Dr. Crawford was outgoing and hard working and always did his homework on council matters.

"He had a wonderful sense of humor," Hall said. "He liked all people. He was an effective councilman. He was a thoroughly honest and dedicated councilman. It was a pleasure to work with him."

Dr. Crawford was born in Christiansburg, Va., and received an A.B. degree from West Virginia University and then obtained his medical degree from Jefferson Medical College in Philadelphia in 1943. He interned at the U.S.N. Hospital in Great Lakes, Ill., and completed residencies at the U.S.N. Hospital in Portsmouth, Va. and Harper Hospital in Detroit. He served for four years in the U.S. Navy as a lieutenant.

Following his military service, Dr. Crawford opened his practice for general surgery in Charleston and joined the WVSMA and Kanawha Medical Society. A member of the American Society of Abdominal Surgeons and the American College of Surgeons, Dr. Crawford was also former president of the West Virginia University Alumni Association and a member of St. Mark's United Methodist Church, Masonic Lodge 27 and Sigma Chi fraternity.

Surviving: son, Robert Alexander Crawford III of Woodstock, Ga., Michael Dillon Crawford of Rocky Mount, N.C., Samuel David Crawford of Atlanta; daughters, Carolyn Crawford Gandy of Mooresville, N.C., Molly Crawford Thompson of Charleston; and 12 grandchildren and one great-grandson.

The family suggests memorial contributions to the Alzheimer's Association, 400 Allen Drive, Suite 20, Charleston, WV 25302.

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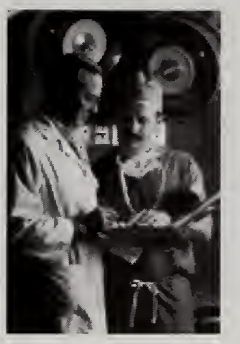

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Seminars

At Death's Door: What Influences Life's Choices?
Tuesday, Aug. 3, 1999
12:30 p.m. to 4 p.m.
Wednesday, August 4, 1999
8 a.m. to 4 p.m.
Geary Auditorium
University of Charleston
Charleston, WV

West Virginia Neurosurgical Society
Saturday, Aug. 14, 1999
8 a.m. to 4 p.m.
Embassy Suites, Charleston, WV
Constantino Y. Amores, MD
Stephen M. Bloomfield, MD
Program Chairmen

Fundamental Critical Care Support Provider Course
Aug. 21 and 22, 1999
8 a.m. to 5 p.m.
Camcare Health Education and Research Institute
Education and Training Center
3211 MacCorkle Avenue SE
Charleston, WV
Frank C. Lucente, MD
Program Chairman

10th Annual Respiratory Care Conference
Advanced Trends in Critical Care Management
Wednesday, Sept. 1, 1999
8 a.m. to 3 p.m.
Robert C. Byrd Health Sciences
Center of West Virginia University/
Charleston Division, Auditorium

3rd Annual Pediatric Critical Care Conference
Thursday, Oct. 14, 1999
8 a.m. to 3:15 p.m.
Robert C. Byrd Health Sciences
Center of West Virginia University/
Charleston Division, Auditorium
Manuel Caceres, MD
Program Chairman

9th Annual Vascular Surgery Conference
Saturday, Oct. 16, 1999
8 a.m. to Noon
Robert C. Byrd Health Sciences
Center of West Virginia University/
Charleston Division, Auditorium
Ali F. AbuRahma, MD
Program Chairman

14th Annual Trauma Conference
Friday, Nov. 5, 1999
8 a.m. to 4 p.m.
Tamarack, Beckley, WV
James W. Kessel, MD
Program Chairman

On-Site Continuing Education Outreach Programs

Diagnosis and Treatment of Congestive Heart Failure
Monday, Aug. 2, 1999
5:45 p.m.
Sycamore Creek Golf Club
Ripley, WV
William Carter, MD

Lacrosse Encephalitis
Wednesday, Aug. 4, 1999
12:30 p.m.
Montgomery General Hospital
Montgomery, WV
James McJunkin, MD

Lymphoma Update
Wednesday, Aug. 18, 1999
6 p.m.
Man ARH
Man, WV
Justin Cohen, MD

Diagnosis and Treatment of Back Pain
Wednesday, Sept. 1, 1999
12:30 p.m.
Montgomery General Hospital
Montgomery, WV
Constantino Y. Amores, MD

Congenital Heart Disease in Pediatrics
Friday, Sept. 10, 1999
Noon
Logan General Hospital, Logan, WV
John Eckerd, MD

Wound Care - Part II
Wednesday, Sept. 15, 1999
6:00 p.m.
Man ARH
Man, WV
Scott Spradlin, DO

Treatment of Type I and Type II Diabetes
Tuesday, Sept. 21, 1999
6:30 pm
Roane General Hospital
Spencer, WV
Steven A. Artz, MD

Guest Lectures/Tumor Conference

Current Management of Breast Cancer
Monday, Aug. 23, 1999
Noon
Robert C. Byrd Health Sciences
Center of West Virginia University/
Charleston Division, Room 2000
Patrick McGrath, MD
University of Kentucky Medical Center
Lexington, Kentucky

Phase I Trial: Metastatic Breast Cancer
Monday, Sept. 13, 1999
Noon
Robert C. Byrd Health Sciences
Center of West Virginia University/
Charleston Division, Room 2000
Brenda Nicholson, MD
Vanderbilt Medical Center
Nashville, TN

Colon-Rectal Cancer
Monday, Sept. 27, 1999
Noon
Robert C. Byrd Health Sciences
Center of West Virginia University/
Charleston Division, Room 2000
Richard Pazdur, MD
M.D. Anderson Medical Center
Dallas, Texas

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West Virginia Medical JOURNAL

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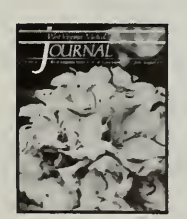

On The Cover

A rhododendron cultivated by Janie Hill of Morgantown reminds us it's time for the WVSMA's Annual Meeting at The Greenbrier.

Photo courtesy of Dr. Ronald Hill of Morgantown.

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Manuscript Guidelines

All articles for the *West Virginia Medical Journal* must be submitted on an IBM compatible disk. Microsoft Word 97 is preferred, but other languages are acceptable. If the manuscript contains tables, the main body of the manuscript and references should be saved as one item, i.e., *article*, and then each table should also be saved as a separate item, i.e., *Table 1, Table 2.*

All scientific manuscripts should be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."* Papers will not be considered for publication if they have already been published or are described in a manuscript submitted or accepted for publication elsewhere. All persons designated as authors should have participated enough in the work to take public responsibility for the concept.

Manuscripts should be accompanied by one extra copy, be double-spaced, have each page numbered and should include a title page, an abstract of no more than 150 words, and references numbered consecutively. No more than 10 references will be published and then a statement will appear that the author should be contacted for the other references listed in the manuscript.

Tables, figures and photos should be numbered, and indicated with parentheses whenever they are mentioned in the text, i.e. (Table 1), (Figure 1). Legends should be included for all figures and photographs.

Photos must be unmounted glossy prints in a 5 x 7 format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author at a cost of $13 for each photo. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be created in black and white.

All scientific material is reviewed by the editor and three members of the Publication Committee. Other articles are usually only reviewed by the editor. All articles should be addressed to:

Stephen D. Ward, M.D., Editor
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If you have questions or need more information, phone Nancy L. Hill, managing editor at (304) 925-0342.

Not ready to fade away

As I sit here writing my last presidential column,these thoughts come to mind.

First - How much fun it has been going around the state and meeting everyone.

Second - How frustrating it can get because of our own apathy. To the members who come out to the WVSMA and component society meetings, thank you for your good input. To the rest of you — get involved. Apathy is killing us. We have the largest access to people of anyone. If we can't get reform in health care, it is our own fault. If we could spend just a few minutes with our patients, our friends, our legislators — simply talking to them — it would make a world of difference. The solutions of the health care industry won't simply drop out of the sky for us.

I have been asked to make available some of the information I used in my talk about the crisis in health care that I gave to many of the component societies during the past year. Here are some some of the most important statistics:

- Currently, 15% or 42 million people in the U.S. have no insurance.
- The National Health Care expenditures will double to over two trillion dollars in the next decade, whereas back in 1970, these expenditures amounted to 13 billion dollars.
- The demand for physician services increases every year by 3%-4%. We all know why — increased consumer demand, new technology and wider choices.

At the same time, we have a serious problem with tort reform. Not just for physicians, but for everyone. It is important to note:

- Right now, 57% of every dollar spent on damage suits, goes to court and lawyer fees.
- It is estimated that 2.5 is added to the cost of <u>any</u> product to cover this added expense.
- Twenty percent of businesses won't bring out new products because of the fear of lawsuits. We all pay the price for this — it hurts our economy and decreases jobs.

What about the future? We need a health care system that covers <u>all of the people.</u> People need insurance that they understand and control. At present, people often get fragmented care. They can't get coverage for referrals when they need them, or get in to see a physician when they need one. This is a situation that we can fix, and we will fix, but we need everyone's help.

The provider tax **must** go, but it won't simply go away until an alternative revenue source is found. Last year alone, physicians provided $24 million to this tax. The total amount was $127 million.

In my inaugural address last August, I stated that we are professionals — we don't simply have jobs. We need to make the effort — only we can. We don't need or want non-medical people deciding our fate or especially the fate of our patients. We need to be proud of ourselves — "sign our own work" — and not blame the problems in today's health care on everyone else.

The WVSMA has come a long way this year. We have an excellent staff who is working hard to better meet the needs of all of our members. They all hold my utmost regard and thanks. I wouldn't have been able to accomplish very much this year without them. One last thank you to Nancie Albright who kept me interested and involved. She is probably the major reason I ran for the presidency in the first place.

It's been a true honor to have served as your president this past year, but I don't plan on fading away just yet. Thanks again.

David W. Avery, M.D.

A medical union?

Are medical societies organized for the benefit of doctors or of patients?

We, of course, have been the object of criticism for years alleging we are primarily self-interested and have had the selfish goal of becoming unionized in order to promote self interest. Not by any chance coincidental is the curious fact that the chief prosecutors in such calumny have been unions and their political supporters both, of course, past masters at promoting self interest and ordinarily quite active in urging anyone able to afford union dues to get out their placards.

One would have to look deep into the history of AMA's political activity to find the slightest evidence whatsoever that our lobbying efforts were based on anything other than concern for the health of our patients. Our main concerns have consistently been that physicians are well trained and that their medical care has met standards of excellence in their training of physicians, their failures have been made public and their programs discontinued.

Perhaps AMA's most vigorous political effort and its greatest failure was its opposition in 1964 to the original efforts to enact what has developed into what is known as the Medicare law. We did expend considerable time, effort and money in resisting that. Our opposition was based on a certain conviction that government and private insurance costs could not be controlled under the proposal and that futhermore the incomes of physicians along with those of any others involved in care would increase dramatically, perhaps uncontrollably. To this day, nothing has proved us incorrect in our assessment or wrong in our opposition. We long ago abandoned that opposition and we continue attempts to make that law workable.

Over the years, AMA has recognized the danger to the health of American citizens were physicians to be allowed the fearsome benefits of group denial of care for patients in the same manner that union members are permitted to menace the general public by witholding their services from employers.

Interesting conflicts have developed in recent years between physicians pushing for union status for AMA and resistance to this by AMA hierachy. Practicing physicians have felt a developing sense of impotence in regard to their ability to manage care of their patients and their ability to manage their own lives and practices free of harassment and intimidation from uncaring government and insurance functionaries who know and care for nothing other than the fixed regulations for diagnoses displayed on their computers. Physicians now see government, insurance companies and hospital boards dictating medical judgments which threaten the health and well being of their patients. There is no other group of citizens other than perhaps members of the armed forces who are subject to such dictates from on high. Physicians search for some way to equalize the conflict. Unionization is their current bright hope and they want to somehow do this through AMA.

After debate at the recent annual meeting a decision was reached for AMA to become involved in the formation of a physician union. The options available to AMA in pursuing this goal remain unclear except for commitments to rule out any work stoppages. Such a commitment suggests only that in a hard knuckles contest, we will be reduced to firing marshmallows at the enemy. But perhaps not.

Is it not logical that physicians attempting to organize as a group in order to deal with managed care abuses should be allowed some significant part of the benefits of laws enacted to protect individuals in their negotiations with other individuals or companies holding power to set abusive rules and work conditions for them?

Why could not physician groups be legally authorized to deal with managed care organizations on any issue other than fees or the direct exchange of dollars for services? We have previously pointed out that doctors do not face the risk of being reduced to food stamps under any conceivable circumstances. Doctors do not need union bargaining power to deal with managed care organizatons over dollar disputes. Doctors do need union strength in order to maintain their professional standards in dealing with managed care zealots.

Individual patients of doctors and the entire nation will benefit from the maintenance of these standards. The need for medical unions is upon us. The time for such activity is now.

Stephen D. Ward, M.D.
Editor

Special AMA Delegation Report

The WVSMA delegation to the AMA's Annual Meeting in Chicago, June 20-24, consisted of Delegates Constantino Amores, M.D., James Helsley, M.D., John Holloway, M.D., and Michael Fidler, M.D.; Alternate Delegates Alva Deardorff, M.D., and Stephan Thilen, M.D.; WVSMA President David Avery, M.D.; Council Chairman Thomas Chang, M.D.; American College of Radiology Delegate Ronald Cordell, M.D.; Young Physician Section Delegate Dorian Williams; Young Physician Section Alternate Delegate Joseph Selby, M.D.; WVSMA Executive Director Evan Jenkins and Medical Students Staci Kerr, Heather Skeens, Amanda Bennett, Autumn Whitlock, Matthew Hofeldt, Melissa Jugo, Steve Greer, Brian Grose, Olivia Ostrow and Khrishi Kanth.

Our delegation took part in extensive debate on the subject of collective bargaining, as well issues concerning full and unrestricted licensure for the practice of telemedicine, opposition to pharmacists initiating drug therapy, the study of the effect of hospitalists on resident education and opposition to obtrusive and disrupting audit practices. Since collective bargaining was the overwhelming topic at the meeting, the report for Reference Committee I was devoted to this single issue and it reads as follows:

1. Report Of The Board of Trustees 30 – Formation Of A Collective Bargaining Unit
   Resolution 901 – Collective Negotiating With Health Plans On Issues Other Than The Amount Of Financial Reimbursement
   Resolution 902 – Anti-Trust Relief For Physicians
   Resolution 903 – AMA Collective Bargaining
   Resolution 904 – AMA Support For Physicians In Their Quest To Be Considered Independent Contractors
   Resolution 905 – Collective Bargaining Unit
   Resolution 906 – Recognition And Endorsement Of Contract Bargaining Units By The American Medical Association
   Resolution 907 – Fight For Doctors' Rights
   Resolution 908 – Bargaining Power For Physician Groups
   Resolution 909 – Reform Of Anti-Trust Laws
   Resolution 910 – Federal Antitrust Legislation
   Resolution 911 – Collective Bargaining
   Resolution 912 – AMA Implementation Of A National Collective Bargaining Unit
   Resolution 913 – AMA Collective Bargaining Unit
   Resolution 914 – Alternative To The Development Of A Collective Bargaining Unit For Resident Physicians
   Resolution 915 – Collective Bargaining – An Essential Element Of Private Sector Advocacy
   Resolution 916 – Alteration Of National Labor Relations Act
   Resolution 917 – Formation Of A Labor Organization

RECOMMENDATION A:

Mr. Speaker, your Reference Committee Recommends that the following Substitute Resolution Substitute 901 be adopted in lieu of the recommendations of Board of Trustees Report 30 and Resolutions 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 915, 916, and 917:

HOD ACTION: Substitute Resolution 901 adopted as amended in lieu of the recommendations contained in Board of Trustees Report 30; Resolutions 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 915, 916, and 917:

RESOLVED, that all activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs; and be it further

RESOLVED, that our AMA immediately implement a national labor organization under the National Labor Relations Act to support the development and operation of local negotiating units as an option for employed physicians; and be it further

RESOLVED, that our AMA immediately implement a national labor organization to support the development and operation of local negotiating units as an option for resident and fellow physicians who are authorized under state laws to collectively bargain; and be it further

RESOLVED, that our AMA continue to support the development of independent housestaff organizations for resident and fellow physicians and be prepared to implement a national labor organization to support the development and operation of local negotiating units as an option for all resident and fellow physicians at such time as the National Labor Relations Board determines that resident and fellow physicians are authorized to organize labor organizations under the National Labor Relations Act; and be it further

RESOLVED, that our AMA continue to vigorously support antitrust relief for physicians and medical groups by actively supporting federal legislation consistent with the current principles of the Quality Health Care Coalition Act of 1999 (H.R. 1304 introduced by Representative Tom Campbell, R-CA and John Conyers, D-MI), aggressively working with the Department of Justice and the Federal Trade Commission, and continue providing model legislation and information on the state-action doctrine to state medical associations and members; and be it further

RESOLVED, that our AMA be prepared to immediately implement a national organization to support development and operation of local negotiating units as an option for self-employed physicians and medical groups when the current principles of the Quality Health Care Coalition Act of 1999 (H.R. 1304) become law; and be it further

RESOLVED, that our AMA continue to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payors; and be it further

RESOLVED, that should the Board of Trustees determine that the Quality Health Care Coalition Act of 1999 (H.R. 1304) or similar legislation will not become law, our AMA immediately pursue the creation or adoption of new antitrust legislation to achieve the same goal.

RESOLVED, that the AMA concurrent to proceeding with the establishment of any collective bargaining unit, undertake an extensive education program, directed at its member and non-member physicians, as to the possible limits on benefits and the risks to the formation of such a unit.

Resolution 916 – Alteration of National Labor Relations Act

HOD ACTION: Resolution 916 not adopted.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Substitute Resolution 901 be changed to read:

FORMATION OF A NATIONAL LABOR NEGOTIATING ORGANIZATION

HOD ACTION: change in title approved.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the remainder of Board of Trustees Report 30 to be filed.

HOD ACTION: remainder of Board of Trustees Report 30 filed.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 914 be amended by deletion in the second resolve and deletion of the third resolve, to read as follows:

RESOLVED, that the American Medical Association support and reinforce mechanisms within the Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME) to address and resolve resident issues at the program and institutional levels; and be it further

RESOLVED, that Policy H-310.933, calling for the AMA to assist in the development of independent (professional) housestaff organizations, be reaffirmed. Further, the AMA should encourage the ACGME immediately to convene a task force drawn from its sponsoring organizations to develop a model for a professional housestaff organization that can serve as a vehicle to address and resolve conflicts between housestaff and sponsoring institutions; and be it further

RESOLVED, that the AMA immediately develop and implement mechanisms to provide direct assistance to individual residents and groups of residents with work-related concerns, such as the creation of a housestaff support unit coordinated by the AMA, and identify the costs of implementation of such a plan. Such a unit should be structured to confidentially address resident issues and conflicts at the program or institution levels and diminish the need for intervention by the ACGME.

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Resolution 914, as amended, be adopted,

HOD ACTION: Resolution 914 adopted.

Respectfully submitted,

Constantino Y. Amores, M.D., Delegation Chair
James D. Helsley, M.D., Delegation Vice-Chair

Medical symbols: One snake or two?

JEFFREY M. JONES, M.D.
Neurologist, Battle Creek, Mich.

Editor's Note: *Dr. Jones is a 1976 graduate of the West Virginia University School of Medicine and he is the historian of the Calhoun County Medical Society in Battle Creek, Mich. He has published several articles on medical history and recently published a book entitled "The Wellness Road: History of Calhoun County Medicine." This article is reprinted with permission from Michigan Medicine.*

The one-snaked staff of Asclepius, the Greek god of medicine, represents the true symbol of medicine. The two-snaked Caduceus is the magic wand of Hermes, the Greek god of chance and messenger boy of the gods, and it is the symbol the public has mistaken for the symbol of medicine. Despite frequent articles in the medical literature, this confusion continues.

The staff of Asclepius

Staff of Aesculapius

Greek mythology tells us that Asclepius was the son of Apollo and Coronis, a nymph. Apollo had Coronis killed while she was still pregnant with Asclepius because Coronis had been unfaithful to him. The infant was saved, however, and handed over to the centaur Chiron. Chiron had acquired knowledge of medicine from Apollo and was entrusted with rearing other such heroes as Jason, Hercules, and Achilles.

Asclepius learned well from Chiron and soon surpassed his mentor. One day while tending a patient, a snake coiled around his staff. Asclepius killed the snake, but another one appeared with a leaf in its mouth and revived the dead serpent. Asclepius kept the leaf, and with it was even more successful in healing people. This incident probably generated what we consider the true medical symbol - the Asclepian staff with a single snake.

Asclepius was so successful as a healer that he could even restore people from the dead. This deprived Hades of much needed subjects, so he prevailed upon Zeus to kill Asclepius with a thunderbolt. Apollo avenged his son's death by shooting arrows at the workmen who made the thunderbolts, the Cyclopes.

Asclepius had six children. Two sons, Machion (surgery) and Podaleirios (internal medicine), are mentioned in the *Iliad* as physician-warriors. His four daughters, Hygeia (health), Panacea (all-healing), Iaso (cure), and Acesis (remedy), personified health and healing.

There is no doubt, then, that the staff of Asclepius is the symbol associated with healing and the art of medicine. In 1910, the AMA officially adopted the staff of Asclepius as its official insignia.

The Caduceus

Caduceus

Apollo and Hades also played a part in the development of the Caduceus. Hermes was the messenger of the gods, the god of commerce, the god of robbers, thieves, and traitors, and also the god who conducted souls to Hades.

Hermes was basically a subtle schemer. When only a few hours old, he escaped from his cradle to search for adventure. He invented the lyre, and when he was caught stealing oxen from Apollo, he used it to charm the father of Asclepius. Apollo let him go unpunished, and Hermes gave him his lyre. In return, Apollo gave Hermes a magic wand that bestowed wealth and prosperity, turning everything it touched into gold. The snakes were added when Hermes separated them from fighting. In appreciation, the snakes wrapped themselves around the staff. Wings became part of the symbol representing Hermes' speed, and this is the origin of the Caduceus.

In other words, the Caduceus was just the wand of a conniving god of thieves who helped folks to Hades, and had nothing to do with medicine, let alone healing. The incorrect use of the Caduceus probably can be attributed to Sir William Butts, who was a physician to Henry VIII. He and several other physicians, as well as some medical publishers used the Caduceus as an emblem, but mostly the use of medical symbols declined in the 17th and 18th centuries.

The staff of Asclepius was first used as the coat of arms of the Medical Department of the U.S. Army in 1818 and by the Medical Corps in 1856. In 1902, though, the Caduceus first started appearing on the lapels of the medical officers in the U.S. Army, and they continue to use them today.

How to deal with the wrong medical symbol

One solution to properly represent medicine is to invent a new medical symbol like the one shown on the right. The cap on the snake should have a logo representing the commercialization of medicine. The arrows and bandages represent all the slings and arrows the legal profession has thrown at physicians. Most importantly, the broken staff with the snake trying to hold it together represents the doctor-patient relationship that changing new health care delivery systems are trying to disrupt.

If a new symbol is not possible, then another obvious solution is to widely publicize the true symbol of medicine. That, however, has been done without success, and has necessitated articles like this.

After further consideration, perhaps only physicians should know the difference. If the message to physicians is "use the staff of Asclepius and heal thyself," then let the message to all those people involved with the commercialism of medicine be, "use the staff of Hermes, and go to Hades!"

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1. **Take inventory of medical/office equipment.**

   Determine the type of equipment you have and the manufacturer for each product.

2. **Contact manufacturers to request compliance letters.**

   Many manufacturers have made sure their products are compliant. You should obtain compliance data and determine what - if anything - should be done before December 31, 1999. If the company claims the product is compliant, you should request the following in writing:

   *The method used, testing procedures and test results to make equipment complaint.

   *Directions for self-testing equipment.

   Although manufacturers' statements don't relieve health care providers from liability, they'll provide the necessary documentation in case of future legal problems.

3. **Determine testing methods for equipment.**

   When you receive the testing instructions, you should determine how to test your equipment. If you have a limited number of products to test, consider testing everything. If you have many devices to test, experts suggest testing a random sample.

4. **Check communication equipment.**

   Phones, fax machines, paging equipment, and office computers should be tested. When consulting manufacturers regarding compliance, you may want to discuss self-testing the equipment. This can be done manually by setting a date in the year 2000 to determine if the equipment will function properly. Desktop computers can be evaluated using commercially available software.

5. **Document actions.**

   Document all efforts. During this process, you'll make many contacts and you should note all information including: dates, names and titles with whom you speak, phone numbers, addresses, and product numbers. Remember, the best way to prove action was taken is with documentation!

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Hip fracture outcomes and their prevention in Kanawha County, West Virginia

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Abstract

Fracture of the hip is a serious and frequent problem in elderly women, often resulting in a considerable loss of function and an increased mortality long after the initial episode. By reviewing medical records coded for fracture of the proximal femur, we determined the incidence of hip fracture and the in-hospital outcomes for women ages 50 and older in Kanawha County during 1995-96. Additionally, we estimated from existing sources the potentially treatable risk factors for prevention of this malady. Our discharge outcomes showed that ambulation status, discharge to home and the mortality rate were similar to national averages; however, the incidence of hip fracture in our subjects was higher than in the most age-specific groups. Physical inactivity, impaired vision, falls, smoking, alcohol intake and a low bone mineral density were identified in our area as significantly prevalent and potentially treatable risk factors. Although hip-fracture prevention can be approached by the individual health care practitioner, community-based programs would appear to be more practical; however, little evidence currently exists to support this type of large scale intervention.

Introduction

Fracture of the hip is a devastating event occurring, primarily, in the later years of life. Women, affected at twice the rate of men, have an 18% lifetime chance of this affliction (1,2).

Care for these individuals involves not only the orthopedic surgeon in the hospital setting, but also the primary care physician, physical therapist, social worker, visiting nurse and the family, long after the acute episode. Although most of the deaths relate to comorbidity and occur within the first six months, the one-year post fracture mortality rate is about 25% (1-3). Virtually all survivors, when compared to control subjects, experience a decline in the social and functional status, as well as more frequent, lengthy and costly subsequent hospitalizations (3). Nearly one-half of these patients are discharged into some type of chronic institutional care, and 15%-25% remain there after the first year (4).

In 1995, hip fractures consumed $8.8 of the $13.7 billion of the U.S. health budget for osteoporotic fractures (5). To combat this health problem, the federal government has set a principal goal of reducing hip fractures in elderly adults (6).

Since the chance of hip fracture increases exponentially with age and West Virginia has one of the largest aging populations in the U.S. (2,7), we conducted a study to find the age-specific rate of women in Kanawha County and their hospital outcomes. These results were compared with similar data from other studies. We also investigated the prevalence of potentially treatable risk factors of hip fracture for women in our region.

Methods

The International Classification of Diseases, Version 9, Clinical Manifestations was used to identify fractures of the proximal femur (820.0-820.9) in three hospitals of Kanawha County (Charleston Area Medical Center, Thomas Memorial and Saint Francis) during 1995-1996; two other smaller hospitals, adjacent to the county (Montgomery General and Boone County), were surveyed for missed cases.

Cases related to metastatic disease and those with an earlier orthopedic procedure on the affected side within the previous year were excluded from the study. A computerized printout was used to identify female gender, age 50 and over and the county of origin by ZIP code.

Age-specific incidence rates were calculated using Kanawha County census data for 1994-1995 (kindly supplied by Alex Lubman, West Virginia University Service and Research, Morgantown, WV). The mortality rate during hospital stay was recorded. Special attention was given to distinguish whether death from hip fracture was related directly to the event and its complications (e.g. pulmonary embolism, pneumonia, etc.), or to associated comorbidities (e.g. coronary events, congestive heart failure, etc.). The functional outcome at the time of discharge was assessed by stratifying ambulatory status as:

(1) able to walk independently;
(2) able to walk independently with a walker device;
(3) able to walk with a walker device but required personal assistance; or
(4) unable to walk.

Table 1. Ambulation status, disposition and in-hospital deaths of 475 women in Kanawha County, aged 50 and older, with hip fracture, 1995-1996.

Discharge outcomes of survivors (n = 457)

Functional status	Percent	Average Age
Ambulatory	1.3	73.3 +/- 10.8
Ambulatory with a walker device	21.0	77.6 +/- 8.8
Ambulatory with walker device & personal assistance	58.9	81.1 +/- 7.8
Not ambulatory	18.8	82.6 +/- 8.4
Discharge disposition		
Home	65.6	79.3 +/- 8.6
Nursing care facility	34.4	82.9 +/- 7.2
Hospital mortality (n = 18)	3.8	85.5 +/- 8.6
Related to hip fracture	0.9	
Cause not directly related to hip fracture	2.9	

Additionally, a notation was made as to whether the patient was discharged to their home or to a nursing home facility.

We estimated the prevalence of risk factors for hip fracture in Kanawha County from existing data (7-10). A one-way analysis of variance was used to analyze age and outcomes; P-values of less than 0.05 were considered statistically significant.

Results

We encountered 475 cases of hip fracture during the two-year period, with a mean ± SD age of 81.0 ± 8.1 years (range 54 to 99). The study outcomes at the time of discharge are shown in Table 1.

Our patients had an average length of hospital stay of 12 days and an in-hospital mortality rate of 3.8%. Survivors displayed a mean SD age of 80.6 ± 8.1 years, whereas, those who died had a mean ± SD age of 85.5 ± 8.7 years ($p < 0.001$). Age was a strong predictor of discharge to home vs. nursing home, as well as ambulation status ($p < 0.001$ in both categories). The hip fracture incidence is shown in Table 2; a dramatic increase of the age-specific rate was noted after the age of 65. The high rate of hip fracture noted in Kanawha County, when compared to the nation and international regions, is shown in Figure 1.

Table 2. Age-specific incidence of hip fractures in women of Kanawha County, 1995-1996.

Rate was calculated on 38,195 women aged 50 and over.

Age Groups	Rate per 10,000
50-54	0.815
54-59	4.14
60-64	6.04
65-69	34.97
70-74	48.71
75-79	107.60
80-84	213.56
85 +	345.62

Discussion

Although in-hospital mortality, functional status and discharge disposition in our patients are similar to the national averages (2,3), we show that the age-specific hip fracture rate is considerably higher (11-13). Since Caucasian women have a higher fracture rate than African-American women and 94.85% of county females, age 50 and older, are Caucasian, higher fracture rates would be expected. However, studies of the geographic variation of hip-fracture rate in the U.S. have substantiated that Caucasian and African-American differences do not account for a higher regional rate (12).

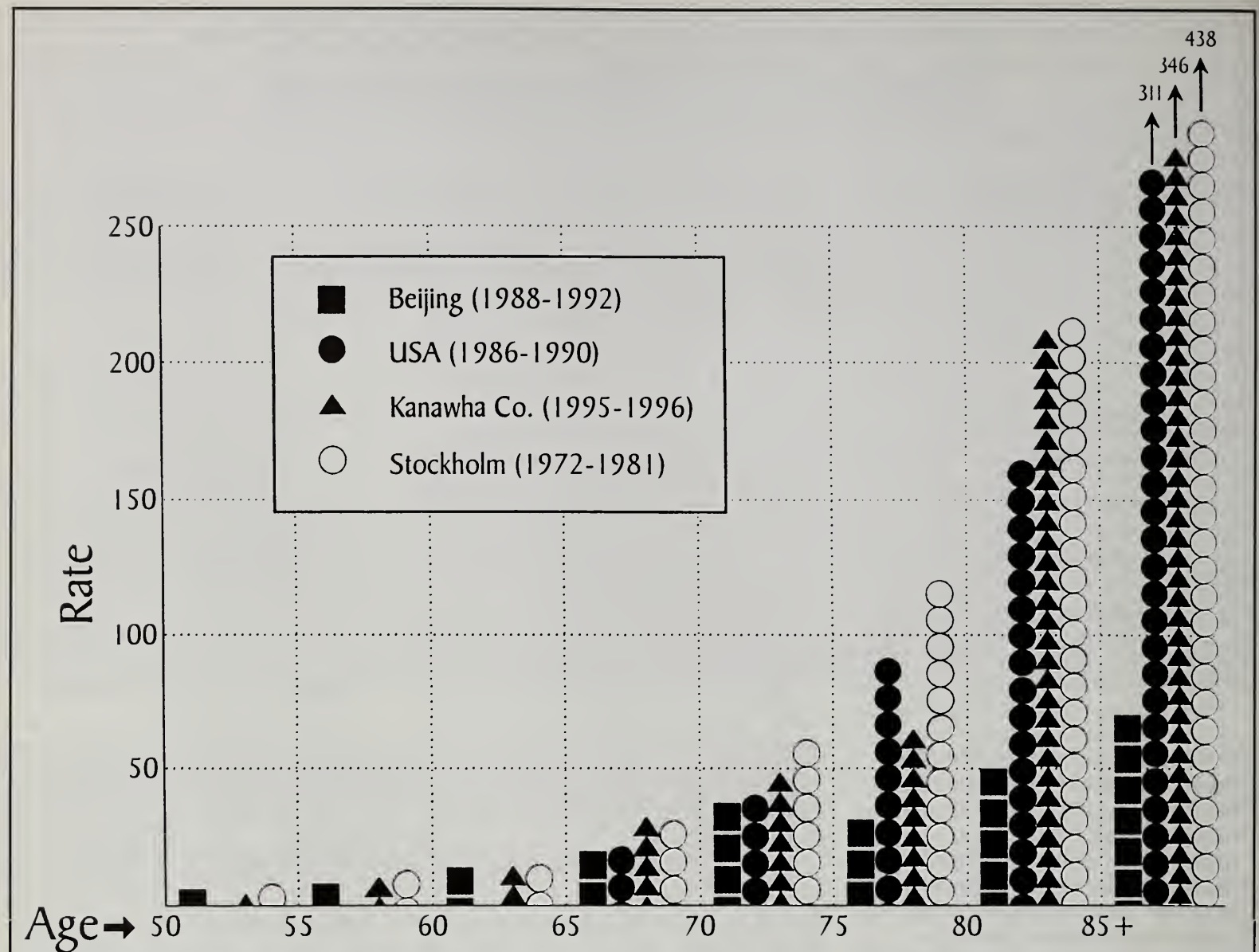

Figure 1. Hip fracture rate in Bejing, China (1988-92), United States (1986-90), Kanawha County, WV (1995-96), and Stockholm, Sweden (1972-1981). Incidence is given in 10,000 person-years.

Many risk factors appear to interact in a complex manner to produce a hip fracture (9,14-16), but the force of the fall and the strength of the hip bone are the two determinants which will ultimately define whether a break occurs (Figure 2). Although hip-fracture prevention requires attacking these numerous factors through community-based efforts and health care providers, we have selected the preventions which are accessible, inexpensive and frequent enough to apply on a wide scale basis (Figure 3).

The main approach of public health programs, in addressing this issue, should be fall prevention. Persons with neurological disorders, frailty, weak quadriceps muscles, poor self-health rating, frequent falls, impaired mobility or balance would theoretically benefit from community-based physical fitness programs (10). It is uncertain whether this type of intervention will affect those with several risk factors already established, but individuals who exercise regularly have shown a reduced risk of fall and hip fracture by 30-60% (16). A prospective study involving a large number of elderly women showed that the amount and intensity of physical activity reduced the hip-fracture rate by 42% (17).

Modifying home environment (e.g. floor lights, shoe style, soft floor padding, unimpeded walking surface, etc.) is estimated to reduce falls by one-third (18). Substantial visual impairment also doubles the risk of hip fracture; community screening programs, with subsequent referrals to health care professionals for correction of visual acuity or cataract surgery, could reduce the rate of hip fracture by 8% (9,18).

Other risk factors such as smoking, which accelerates the rate of postmenopausal bone loss (16), are amenable for correction by community programs or by individual health care givers. A successful anti-smoking campaign, in which one-third of the women are smokers, is estimated to reduce the hip-fracture rate by one-eighth to one-half (9,16). Unfortunately, the long-term success rate of such an endeavor is quite marginal (9).

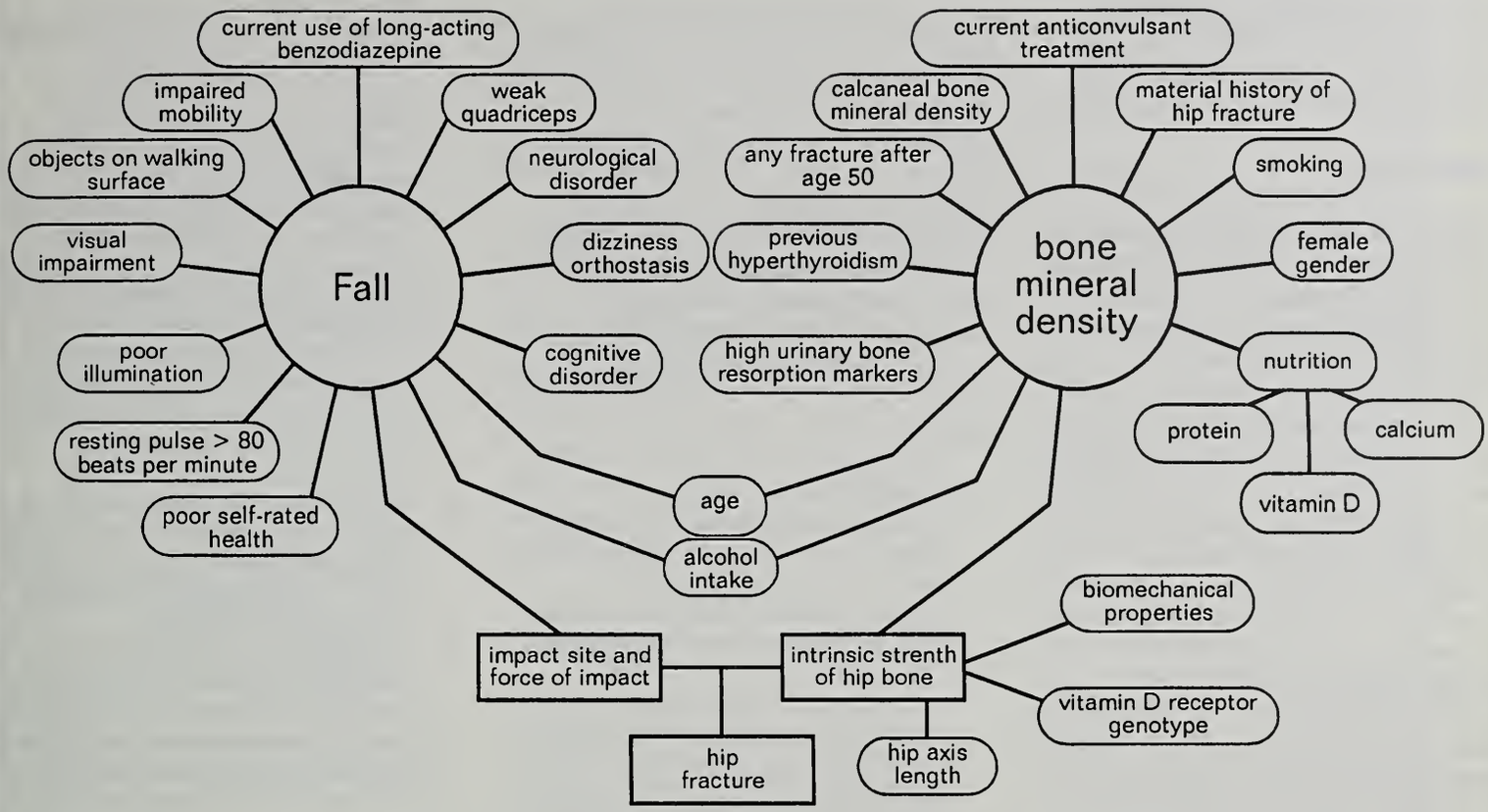

Figure 2. Composite drawing of the interaction of the multiple risk factors in the pathogenesis of hip fracture.

About 12% of elderly women in Southern West Virginia consume at least one or more alcoholic drinks daily (unpublished data, Pfister AK and Saville PD). Although the hip-fracture rate in alcoholics is increased four to eight times, even moderate drinkers have a 30% higher risk (16).

The individual health care practitioner has a focused role in making the hip bone more resilient to fracture by identifying the high risk patient. Higher calcium intakes and vitamin D supplements reduce the rate of hip fractures in nursing home patients; however, they do not convincingly accomplish this when applied to a population of community-dwelling patients (19). Protective hip pads dramatically reduce hip fracture in nursing home patients (20); these can be custom made, inexpensively, by using carpet padding (7/16 inch -- 8 lb. density) to fit under pantyhose and to be placed over the greater trochanters for patients who display a high fall propensity (10).

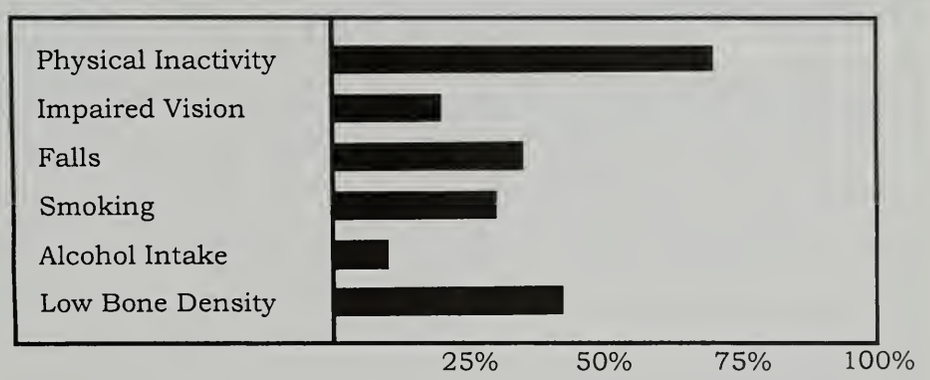

Figure 3. The prevalence of potentially treatable risk factors for hip fracture in women ages 50 and over in Southern West Virginia.

A bone mineral density determination of the hip bone to assess for osteopenia or osteoporosis, appears valuable in treating the individual patient; however, evidence indicates that mass screening would produce only a marginal benefit in reducing the rate of hip fractures (16). Estrogen replacement, a highly cost-effective therapy, reduces hip fractures by 50%; unfortunately, only a minority of women will accept hormone replacement on a long-term basis (16). Alendronate treatment posts a similar reduction in the rate of hip fractures, but long-term compliance rates are not available (21).

Since this study was retrospective, we could not adequately determine, by a

premorbid analysis, the number of potentially preventable risk factors and the prefracture ambulatory status of each individual patient. The absence of these facts limits the interpretation of our outcomes.

Conclusion

There are many risk factors which cannot be treated or altered to prevent hip fracture. Health care providers can intervene in some factors affecting the individual patient, especially when located in geographic regions of high fracture rates. This approach, however, appears to be impractical when applied to an entire population and is unlikely to produce any significant reduction in rates.

A community-based effort through various health care agencies, designed to educate and guide the public about the potentially treatable risk factors, is more ideal; however, the proven effectiveness of such a program currently does not exist.

Acknowledgements

We would like to thank the medical record staffs at Charleston Area Medical Center, St. Francis Hospital and Thomas Memorial Hospital for their help in obtaining medical records; the Camcare Health Education and Research Institute and the CAMC Foundation for funding Jonathan McJunkin as part of a summer externship program; and Ms. Brenda Spencer for her secretarial assistance.

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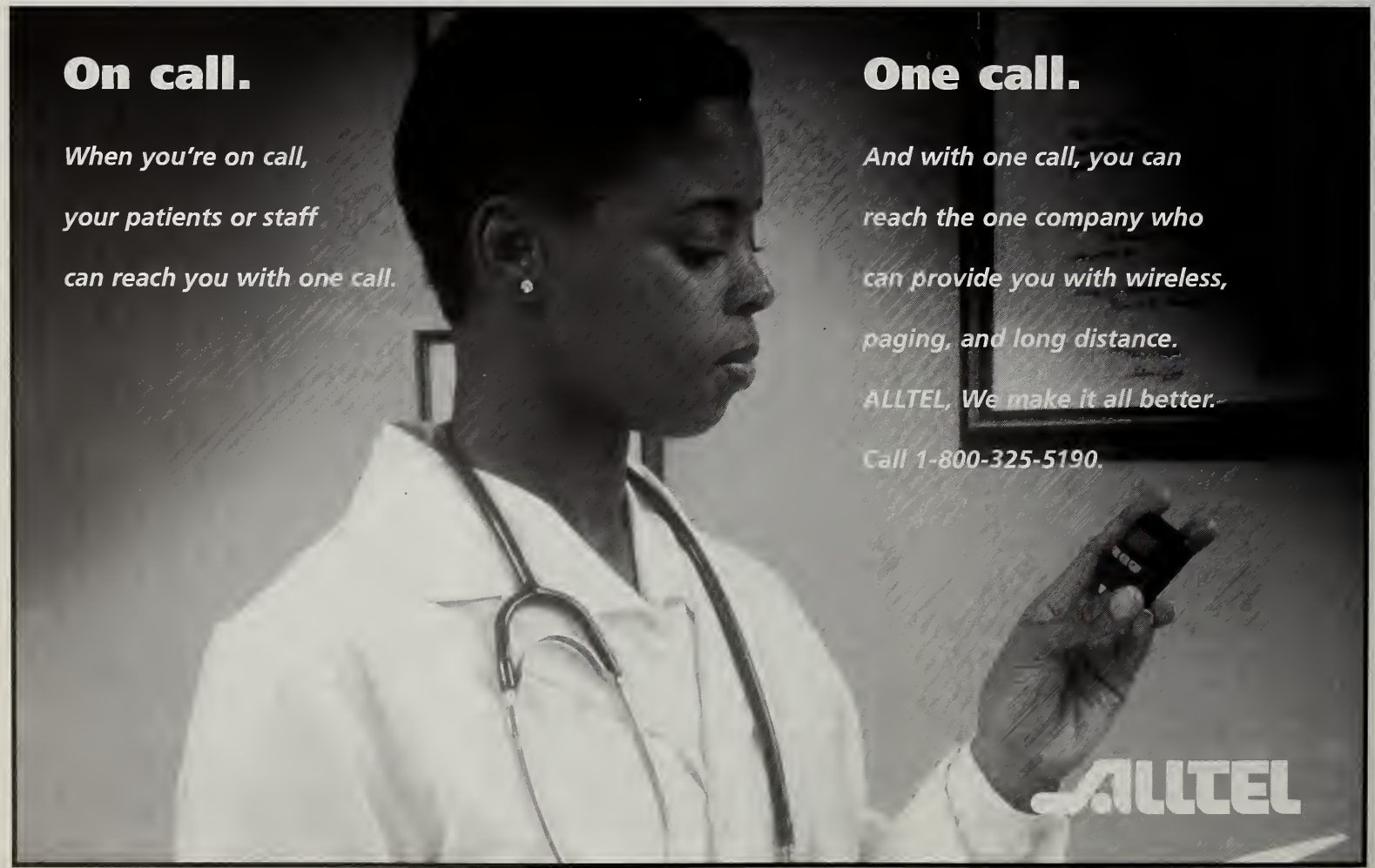

Dyslipidemia evaluated by brachial artery vasoactivity: A case study of eight patients

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Abstract

Current National Cholesterol Education Program (NCEP) guidelines consider a desirable low-density lipoprotein cholesterol level to be < 100 mg/dl for an individual with coronary artery disease (CAD). To assess the affect of these cholesterol levels on endothelial cell functioning, flow-mediated brachial artery vasoactivity was measured non-invasively (7.5 MHz ultrasound) before and during Simvastatin (Zocor) therapy. Vasoactivity was expressed as a percent diameter change from baseline to hyperemic conditions and increased from 2.4+/-3.0% at baseline to 13.1+/-3.4% (p < .05) and 15.1+/-2.7% (p < .01) as cholesterol decreased from 243+/-24.7 to 221 +/-27.3 and 213+/-22 mg/dl after three and six months, respectively, during therapy. LDL cholesterol subsequently decreased from 155+/-22.1 at baseline to 143+/-20.2 and 130+/-10.6 after three and six months of treatment, respectively. In conclusion, vasoactivity was found to correlate inversely with cholesterol levels (r = 0.44). This suggests that vasoactivity responds to changes in cholesterol levels and that endothelial function improves by lowering cholesterol levels.

Introduction

Atherosclerotic CAD has been correlated with elevated levels of LDL and total cholesterol which has been indicated in reduced endothelial function, thus comprising the vasodilator effects of nitric oxide (NO)(1).

HMG-CoA reductase inhibitors completely inhibit the rate limiting enzyme (HMG-CoA reductase) in cholesterol synthesis.

[HMG-CoA (Reductase) —> Mevolonate —> Cholesterol]

These receptors also increase hepatic LDL receptors, thereby increasing the clearance of plasma LDL, leading to an overall reduction in this type of cholesterol. To assess the clinical benefits of lipid lowering, flow-mediated brachial artery vasoactivity is used to determine the improvement in minimal lumen diameter.

Flow-mediated vasoactivity is a sensitive indicator of vascular endothelial function and it is reduced in patients with the coronary risk factors of hypercholesterolemia, hypertension, cigarette smoking, male gender and advancing age (2). In CAD patients, improvement in endothelial cell function can occur by lowering cholesterol levels below recommended NCEP guidelines (LDL < 100) (3, 4, 5, 6, 7).

We studied eight patients with documented atherosclerotic disease at baseline for their brachial artery vasoactivity and the responses were correlated with fasting blood lipids. These patients were followed for six months, and responsiveness to brachial artery vasoactivity was documented and correlated with cholesterol levels while on simvastatin therapy.

Methods

Eight patients between the ages of 40 to 75 with documented CAD by cardiac catheterization (at least one atherosclerotic lesion compromising more than 50% of the luminal diameter) were selected for this study. Patients were evaluated for major risk factors and baseline lipid profiles.

The subjects chosen were not on existing medications, excluding aspirin, and were encouraged to cease the use of all tobacco products. Arterial diameter and blood flow measurements were measured at baseline and after three and six months of simvastatin therapy.

An ultrasonographer measured each subject's flow-mediated brachial artery vasoactivity using a 7.5 MHz linear array ultrasound in a standard 128 XP/10 system (Acuson, Mountain View, Calif.) (3, 7). These measurements were taken in each subject's left arm in a recumbent position while they were in a temperature-controlled room. The diameter of the brachial artery was measured using two-dimensional ultrasound images obtained approximately five centimeters proximal to the antecubital crease, twice at baseline and then at one minute after five minutes of arterial occlusion (with a blood pressure cuff on the upper arm). Photographic images were read using calipers by the sonographer.

Arterial diameter was determined by an average of two measurements along the arterial image. The subject was marked with a pen after baseline measurements were taken to maintain the transducer in a fixed position relative to the subject's arm. Flow-mediated vasoactivity was determined as the percent change in diameter between baseline and hyperemic conditions. After baseline determinations, the subjects were started on simvastatin 20 mg each evening. The doses were titrated according to NCEP guidelines in order to obtain LDL cholesterol of < 100 mg/dl.

Table 1. Total (TC) and Low-Density Lipoprotein (LDL) Cholesterol and Brachial Artery Vasoactivity Before and During Simvastin Administration.

Patient #	Parameter	Baseline	Three Months	Six Months
1	TC/LDL	291/185	251/152	232/121
	%D change	-10.83	7.78	13.2
2	TC/LDL	222/158	198/143	192/133
	%D change	2.48	13.73	11.95
3	TC/LDL	168/125	140/97	129/91
	%D change	8.88	5.42	11.27
4	TC/LDL	220/148	198/126	205/128
	%D change	3.66	13.75	24.83
5	TC/LDL	326/250	295/196	232/141
	%D change	6.06	6.41	20.77
6	TC/LDL	226/125	182/90	239/134
	%D change	5.7	24.43	12.5
7	TC/LDL	269/131	294/200	265/161
	%D change	-1.01	11.93	11.39
8	TC/LDL	223/119	212/136	-
	%D change	4.17	21.21	-
Mean TC		243+/-25	221+/-27	213+/-22
Mean LDL		155+/-22	143+/-20	130+/-11
Mean %D change		2.4+/-3	13.1+/-3.4*	15.1+/22.7**

*$p < 0.05$, **$p < 0.01$ compared to baseline*
%D change = percent diameter change of brachial artery vasoactivity; - not performed; LDL and TC are reported as mg/dl

Fasting serum lipid profiles as well as their brachial artery vasoactivity were documented at approximately three and six months. Correlation was made between lipid levels and change in vessel responsiveness, expressed as mean values +/- standard deviation. Statistical change was analyzed for repeated measurements using an analysis of variance, followed by two-tailed paired t-tests and by linear regression analysis. A p-value of < 0.05 is considered significant.

Results

The mean age of the men studied was 61+/-6 years. LDL cholesterol levels ranged from 119 to 250 mg/dl. Baseline mean lipid values were: total cholesterol, 243+/-25 mg/dl; LDL cholesterol, 155+/-22 mg/dl. Table 1 shows total and LDL cholesterol levels before and during simvastatin treatment. After both three and six months of simvastin treatment, these cholesterol levels were reduced to ($p < 0.01$).

Measurements of individual baseline and flow-mediated vasoactivity during treatment were also recorded (Table 1). A significant inverse correlation between vasoactivity and total cholesterol was found ($r = -0.44$).

Mean flow-mediated vasoactivity was plotted against mean total cholesterol calculations (Figure 1). Mean brachial artery vasoactivity increased from 2.4 +/-3.0% at baseline to 13.1+/-3.4% ($p < 0.05$) and 15.1+/-2.7% ($p < 0.01$) as total cholesterol decreased from 243+/-25 to 221+/-27 and 213+/-22 mg/dl after three and six months, respectively, of cholesterol-lowering therapy. LDL subsequently declined from 155+/-22 at baseline to 143+/-20 and 130+/-11 after three and six months of treatment, respectively.

High-Density Lipoprotein (HDL) increased in all subjects and Triglycerides (TG) decreased in all but one patient during therapy. More than two-thirds of the total increase in flow-mediated vasoactivity was observed in the first three-month period during treatment. Photos 2a & 2b show what a patient's brachial artery ultrasound looks like at baseline and during hyperemic conditions, respectively.

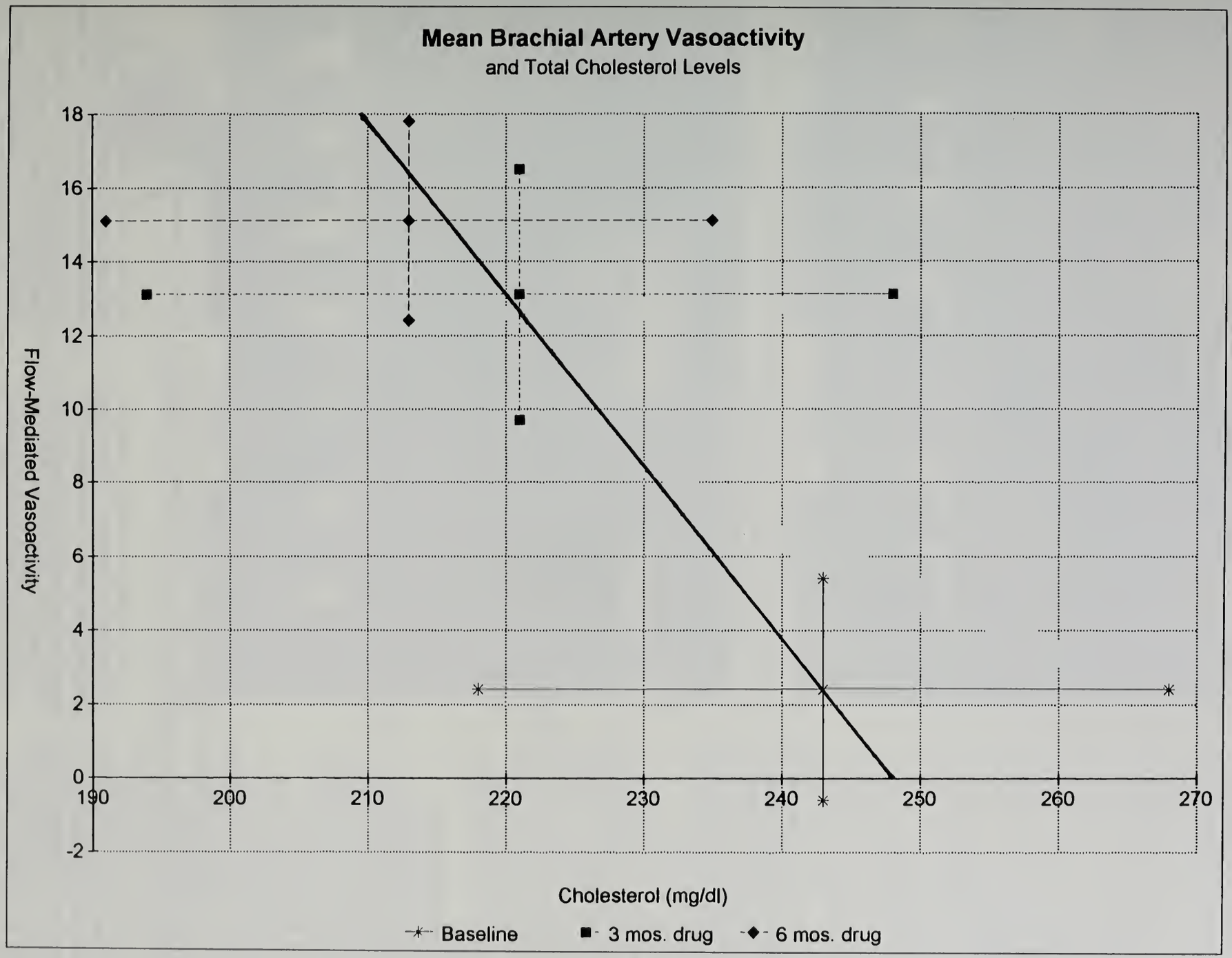

Figure 1. Mean brachial artery vasoactivity for the eight patients at baseline, three months after treatment and six months after treatment.

Discussion

During the course of the study several assumptions were made in order to differentiate the cause of changes in vascular reactivity and lipid levels:

1) Patient takes medication accordingly.
2) Cessation of all tobacco products.
3) Exclusion of diet as contributing factor.
4) Fasting serum lipid levels are measured.
5) Accurate measurements were taken by the sonographer.
   a) reading calipers accurately.
   b) transducer is placed at a fixed position.

Not taking the medication alters the lipid levels resulting in false high cholesterol levels. The use of tobacco products, as well as a diet high in cholesterol, may affect the study by further damage to endothelial cells. All these situations lead to a reduction in the percent change of vasoactivity.

There were two negative percent diameter changes (Table 1). This data is accounted to erroneous readings or measurements by the sonogragher or measurements taken at a different portion of the brachial artery.

The dosing intervals were chosen to allow a significant amount of time for cholesterol lowering. Three and six month intervals were also selected due to the availability of the ultrasound willingness of the patients.

In evaluating the response to therapy, there seemed to be a large increase in the vasoactivity following the first three months (2.4+/-3% to 13.1+/-3.4%) as compared to after six months of therapy (2.4+/-3% to 15.1+/-2.7%). This may suggest a saturation point where the drug continues to lower the cholesterol levels, but recovers endothelial function in a reduced fashion. To determine this, patients could be monitored every two weeks or month (during therapy) and see when the increase in vasoactivity is at its greatest and if it follows an exponential curve.

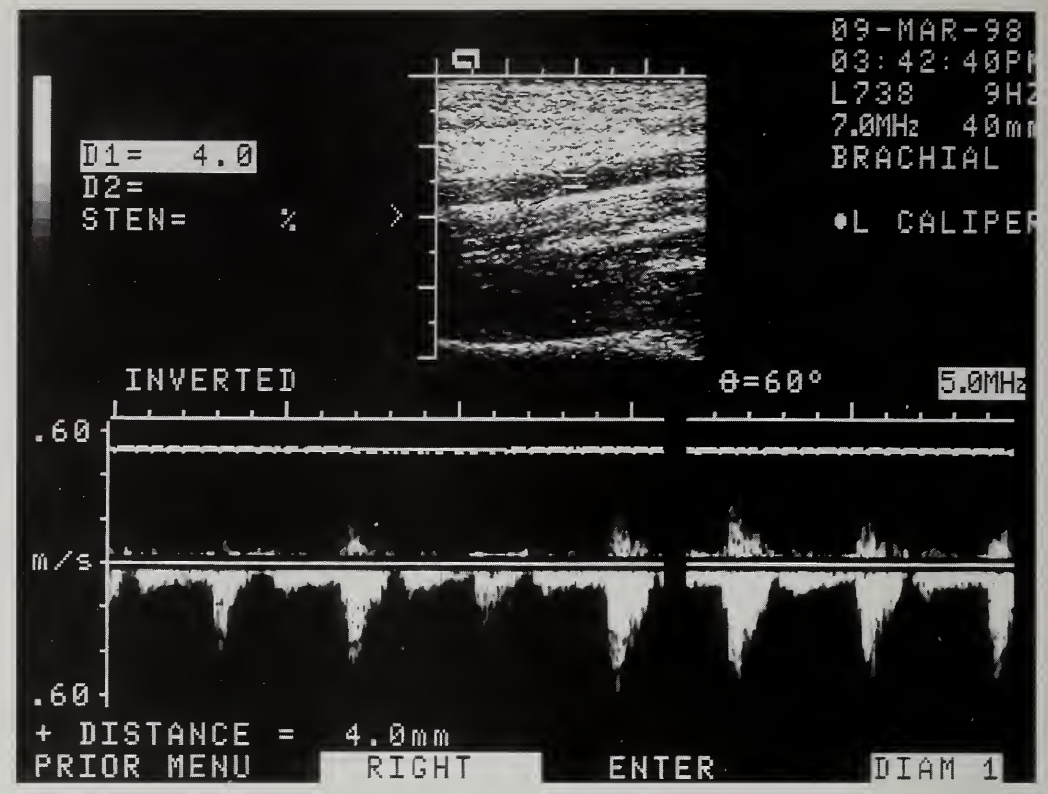

Figure 2a. A brachial artery ultrasound at baseline.

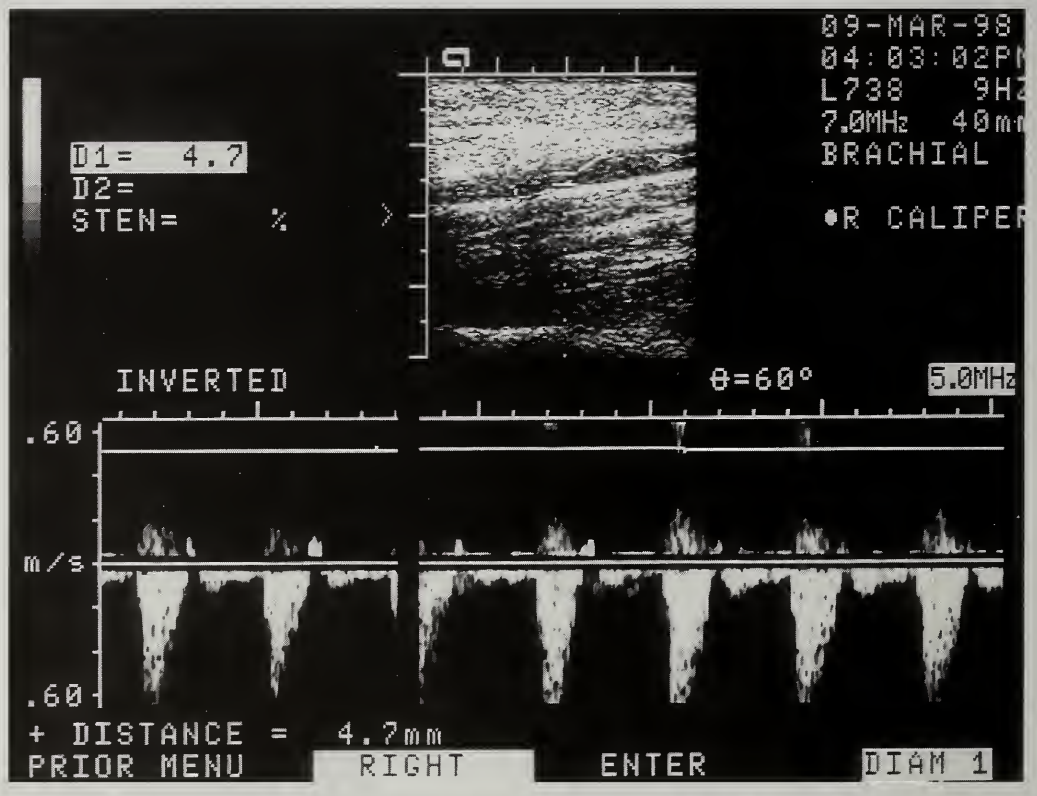

Figure 2b. A brachial artery ultrasound during hyperemic conditions.

The average minimal lumen diameter at baseline, before and during treatment, is relatively similar for each respective patient. However, during hyperemic conditions there is the greatest discrepancy between vasoactivity and a futher discrepancy between pretreatment and treatment conditions. The first explanation for this change in vasoactivity is that the drug, independent of all other criteria, causes the increase in flow and diameter. The second is that, the reduction in lipids (especially LDL cholesterol) acting on the endothelium of the coronary and brachial arteries results in recovery of endothelial cell function and the vasodilator effects of NO.

Patient #6 showed the most change in vasoactivity (24.43%) and met the goal of LDL < 100 mg/dl in the first three months, but rebounded to 12.5% and an LDL of 134 mg/dl. This suggests human error or partial or discontinued therapy over the final three-month period. Patient #3 also met the goal of LDL < 100 mg/dl and showed an increase in vasoactivity over the entire six-month period.

Conclusions

Reduced endothelial function is associated with CAD along with the risk factors: hypercholesterolemia, smoking, diabetes, hypertension, advanced age and male gender.

Nitric oxide is a potent vasodilator in the endothelium. Injury to the endothelium and thus NO may compromise vasoactivity in the artery. Hypercholesterolemia may itself initiate endothelial dysfunction or allow the oxidative modification of LDL which inactivates NO through stimulation of endothelial superoxide anion production.

Vasoactivity was found to correlate inversely with cholesterol levels (r = -0.44). This suggests that flow-mediated brachial artery vasoactivity responds to changes in cholesterol levels and that endothelial cell function improves by lowering cholesterol levels.

Therefore, the cholesterol-lowering therapy suggests improved endothelial cell function and vasoactivity in arteries. This reduces the risk of complications resulting from CAD and maybe used to control and prevent CAD and its complications in the future.

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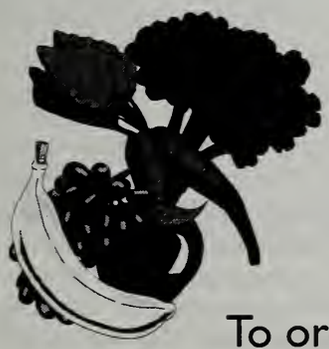
The DASH* Diet

*Dietary Approaches to Stopping Hypertension Trial
Appel, LJ et al., NEJM, 336 (16), 117-24, 1997

The findings:

- This landmark study found that consuming at least three servings of lowfat dairy products, eight servings of fruits and vegetables and a diet reduced in total fat and saturated fat, can help to significantly lower blood pressure.



Tips for a "DASHing" diet:

- Re-think your drink, choose milk more often.
- Add Pizzazz to your cheese pizza, top with lots of veggies.
- Dip, dunk and swirl raw fruits and veggies in a yogurt based dip.

To order FREE information on the DASH diet including a full-page reproducible master, call 1-800-778-MILK.

Request item #110

Check out Dairy Council's website for up-to-date nutrition information at www.nationaldairycouncil.org

Dairy Council Mid East, an affiliate of National Dairy Council

Status of women in academic medicine at West Virginia University School of Medicine

JANET M. WILLIAMS, M.D., F.A.C.E.P.
Associate Professor, West Virginia University Center for Rural Emergency Medicine, Morgantown

(Dr. Williams has written this article on behalf of the members of the Committee on Women in Academic Medicine at West Virginia University.)

Abstract

The Committee on Women in Academic Medicine at West Virginia University conducted a study to compare the status of women in academic medicine at West Virginia University with national averages. We obtained data on gender distributions, ranks, degrees, and admininstrative titles of full-time women faculty members. Our data showed that 26% of WVUSOM faculty are women. This fell short of the national average within some departments and exceeded the national average in others. Our data also indicated that among women faculty, 15% are full professors (10% nationally), 27% are associate professors (19% nationally), 51% are assistant professors (50% nationally), and 7% are instructors (17% nationally). No clinical departments, and only two basic science departments, are chaired by women. We conclude that the proportion of women faculty and differences in rank distributions at WVUSOM mirror national trends with few exceptions. There is a lack of women in senior positions including full professors, departmental chairs, division chiefs, and academic deans at WVUSOM.

Introduction

Women constitute approximately 42% of the total enrollment in U.S. medical schools and roughly 34% of all residency positions. The proportion of full-time medical faculty who are women has increased from 15% in 1975 to 26% in 1997 (1).

Despite the increasing numbers of women entering medicine, several studies have shown that women are less likely than men to attain a high level of academic ranking or to hold a major administrative position within academic medicine (2). Moreover, women faculty are compensated at lower levels than are men at all academic ranks, even when controlled for experience, seniority, and discipline (2).

The goal of this study was to report on the status of women in academic medicine at West Virginia University School of Medicine (WVUSOM) and to compare these statistics to the rest of the nation.

Methods

Data from 1996-97 were obtained from the Office of the Vice President of the Robert C. Byrd Health Sciences Center at West Virginia University and included the following variables:

(1) gender distribution of full-time faculty collectively as well as stratified by academic department,
(2) distribution of faculty by rank and gender collectively as well as stratified by academic department,
(3) distribution of faculty by gender and academic degree, and gender distribution of medical school administrators.

Data were entered into a Microsoft Excel spreadsheet, and a detailed analysis was performed.

Results

Of the 497 full-time WVUSOM faculty, 26% are women, and the proportion of women faculty within certain departments varies widely.

In the basic sciences, the departments of anatomy and physiology have the lowest number of faculty who are women (12.5%), while the proportion of women faculty in the departments of biochemistry, pathology, and pharmacology, exceeds the national rates as a whole.

In clinical departments, the proportion of women faculty was found to be lower than the national average in orthopedics, urology, anesthesiology, otolaryngology, family and community medicine, and obstetrics and gynecology. The proportion of women faculty in clinical departments at WVUSOM is highest in emergency medicine, behavioral medicine, internal medicine, neurology, ophthalmology, radiology, and pediatrics and exceeds the national distribution. Data on how WVUSOM and the nation compare with respect to proportions of women faculty by clinical and basic science departments are shown in Table 1.

Figure 1 shows the proportions of faculty by academic rank and gender. Among all women faculty, 15% are full professors (compared to 10% nationally), 27% are associate professors (19% nationally), 51% are assistant professors (50% nationally), and 7% are instructors (17% nationally).

In contrast, the levels of academic rank among male faculty were found to be equally distributed in thirds among assistant, associate, and full professor. This pattern of rank distribution among male faculty at WVUSOM is very similar to the national data for males. In fact, the proportion of male faculty at the rank of professor has remained stable at 32% for over 15 years in the U.S.

Table 1. Distribution & Rank of Women Faculty By Departments at the WVU School of Medicine Medicine+1997.

	Total		(National)*	Asst. Professor		Assoc. Professor		Professor	
Basic Science									
Anatomy	2	12.5%	(24%)	0	0%	2	33%	0	0%
Bio Chem	4	33.3%	(22%)	1	20%	1	50%	2	50%
Microbiology	3	23.0%	(24%)	3	60%	0	0%	0	0%
Pathology	10	47.6%	(28%)	3	60%	3	50%	4	40%
Pharmacology	3	23.1%	(21%)	0	0%	1	100%	2	22%
Physiology	2	12.5%	(19%)	0	0%	0	0%	2	25%
Clinical									
Anesthes	5	21.7%	(26%)	2	20%	2	67%	0	0%
Behav Med	23	34.9%	(33%)	14	38%	9	37%	0	0%
Com/Fam Med	13	20.6%	(33%)	9	30%	1	6%	3	27%
Emer Med	4	36.4%	(24%)	2	40%	2	50%	0	0%
Medicine	24	28.2%	(24%)	13	48%	5	20%	3	10%
Neurology	3	27.3%	(23%)	2	100%	1	25%	0	0%
Neurosurgery	0	0%	(NA)	0	0%	0	0%	0	0%
Ob/Gyn	7	28.0%	(37%)	4	33%	0	0%	0	0%
Occ Med	0	0%	(NA)	0	0%	0	0%	0	0%
Ophthalmology	3	27.3%	(22%)	0	0%	3	60%	0	0%
Orthopedics	0	0%	(10%)	0	0%	0	0%	0	0%
Otolaryngology	0	0%	(21%)	0	0%	0	0%	0	0%
Pediatrics	26	46.4%	(40%)	13	54%	10	53%	1	11%
Radiology	6	25.0%	(21%)	4	40%	1	11%	1	25%
Surgery	3	11.5%	(11%)	1	17%	1	17%	1	8%
Urology	0	0%	(NA)	0	0%	0	0%	0	0%

**Source: AAMC Women in U.S. Academic Medicine Statistics, 1997.*

NA = Not Available

†Number of women at each level of academic rank as well as the % ratio of women to men within each level of rank.

Table 1 also indicates the proportion of women faculty within each department along with the proportion of women and their academic rank. Overall, women accounted for only a minority of full professors in both basic science and clinical departments.

Our research revealed that the proportion of all full professors at WVUSOM who are women is 19/142 or 13% (compared to 11% nationally). The proportion of all associate professors who are women is 35/145 or 24% (compared to 22% nationally). Of all assistant professors at WVUSOM, 65/184 or 35% are women. Nationally, the average number of full professors who are women per medical school is 19, including non-tenured and basic sciences faculty, compared to 157 male professors per school.

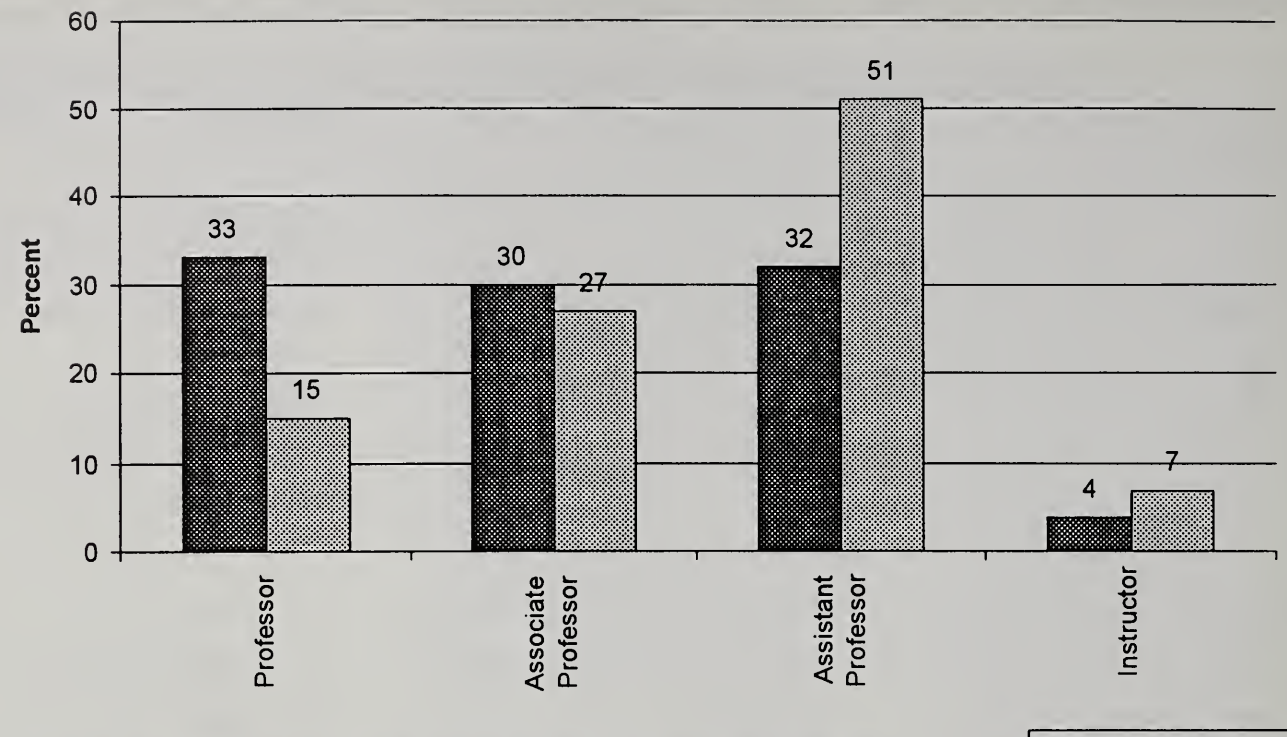


Figure 1. Full-time WVU School of Medicine faculty by rank and gender.

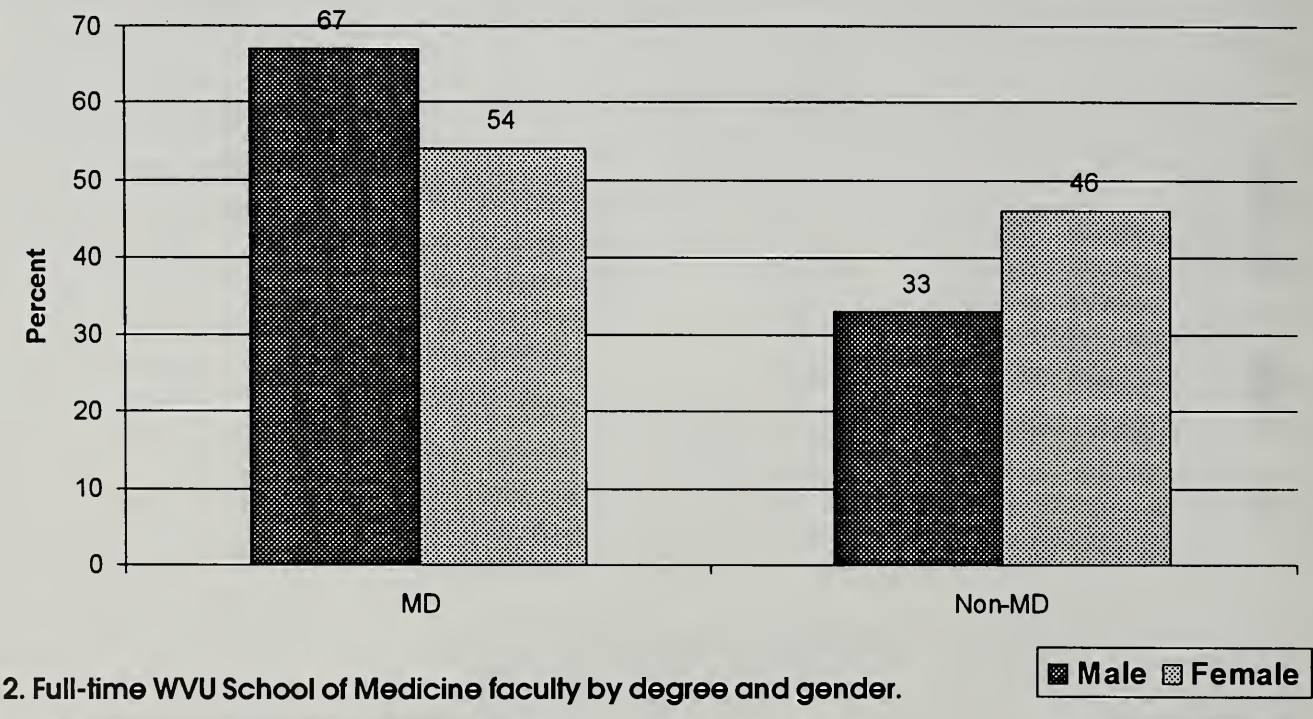


Figure 2. Full-time WVU School of Medicine faculty by degree and gender.

Figure 2 shows distribution of WVUSOM faculty by degree: 69/128 or 54% of women faculty at WVUSOM are M.D.s, and 248/369 or 67% of males are M.D.s (compared to 58% and 65%, respectively, nationally).

Nationally, less than 5% of all academic chairs are women, and less than 3% of med school deans. Currently, there are 183 women medical department chairs and seven women med school deans in the U.S. At the time this study was conducted at WVSOM, no clinical departments were chaired by women and only two basic science departments (pathology and biochemistry) were chaired by women (Table 2).

Thus, despite the fact that 26% of WVUSOM faculty are women, only 8% of department chairs are women. Although, one associate chair position is held by a woman (pediatrics) and there is one female associate dean, no woman has ever served as dean and there are no other women serving in senior administrative positions.

Table 2: Women in Administrative Positions at WVU School of Medicine.

Position	Number	Percent
Director	6	30%
Associate Director	1	25%
Associate Dean	1	14%
Chairperson	2	8%
Associate Chairperson	1	17%
Section Chief	1	7%

Discussion

The data from this study indicates that although one-fourth of the WVUSOM faculty are women, there is a paucity of women in senior positions including full professors, departmental chairs, division chiefs, and academic deans.

The reasons often cited for why women are not succeeding at the same pace as men include isolation, lack of mentoring and role models, sexism, and cultural stereotypes (3). In addition, women in academic medicine have had to fulfill the same expectations of their male counterparts without regard for the fact that they usually carry the primary responsibility of caring for their families and homes. Work-family conflicts often contribute to the exodus of junior women faculty from academic medicine and the lack of women leaders in medicine (4). Further studies are warranted to determine factors contributing to the lack of women in senior academic and leadership positions.

Many studies have suggested that gender bias exists in academic medicine in both promotions and salaries. In addition, in some settings, women have been shown to carry a heavier load of service and teaching responsibilities than their male counterparts. A variety of approaches have been suggested to enhance the growth of women in academic medicine such as programs designed to develop leadership skills and to mentor women faculty, increased flexibility in areas such as time lines to promotion and part-time academic positions, as well as recognition of the work-family conflict as a legitimate concern that does not indicate a lack of commitment to a career in academic medicine (3,4).

Continued efforts are needed to develop ways to retain women in academic medicine as well as improve pathways to leadership.

Conclusion

The proportion of faculty who are women, as well as differences in rank distributions between the genders at WVUSOM, mirror national trends with few exceptions. Similar to the nation as a whole, there is a lack of women in senior positions at WVUSOM including full professors, departmental chairs, division chiefs, and academic deans.

Efforts are needed to foster the development of women in academic medicine to include pathways to leadership positions.

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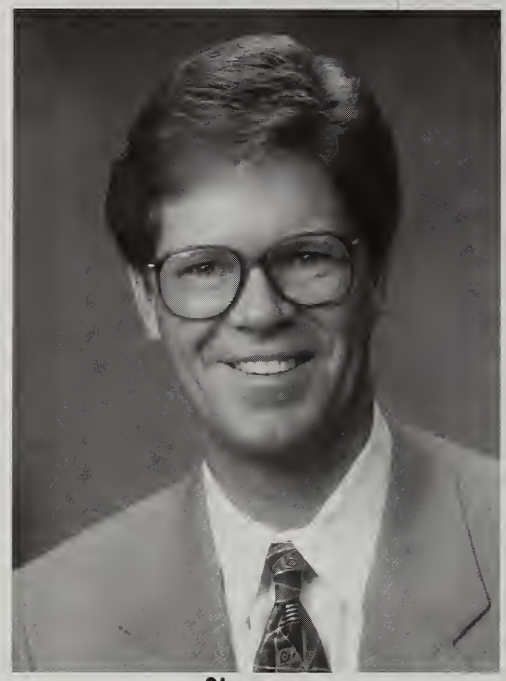
Stevens to be installed as WVSMA president

"Healthcare in the '90s: The Gathering Storm" is the inaugural address which Phillip R. Stevens, M.D., will deliver on Saturday, August 28 when he is sworn in as the new president of the WVSMA. Dr. Stevens' address will be presented during the Second Session of the House of Delegates during the WVSMA's 132nd Annual Meeting at The Greenbrier.

A native of Bridgeport, W.Va., Dr. Stevens received his M.D. degree from the West Virginia University School of Medicine in 1983. He completed a surgical internship at WVU Hospital and then did his residency in the Dept. of Otolaryngology, Head and Neck Surgery at the Ohio State University Hospital.

Board certified by the American Board of Otolaryngology and Head and Neck Surgery, Dr. Stevens has been in private practice in Huntington since 1988. He is on the staffs of Cabell Huntington Hospital, St. Mary's Hospital and Cabell Huntington Surgery Center.



Stevens

Dr. Stevens served on the WVSMA Council from 1993-96, was elected vice president of the WVSMA in 1997 and then president-elect in 1998. A past president of the Cabell County Medical Society and the West Virginia Academy of Otolaryngology, Dr. Stevens is also a member of the American Academy of Otolaryngology and the AMA. He and his wife, Susan, live in Huntington with their four children, Nathan, Laura, Sarah and Molly.

A reception will take place on the Colonial Terrace immediately following Dr. Stevens' inaugural address at approximately 12:30 p.m. to honor him and the other new officers of the WVSMA and WVSMA Alliance. Broadway performer Mark McVey, who is a Huntington native, will entertain at the reception, which is being hosted by the Cabell County Medical Society.

Romero to take office as president of Alliance

Rose Romero will be installed as the 75th president of the WVSMA Alliance during the WVSMAA's Annual Meeting at The Greenbrier, Aug. 26-28. During her year as president, Rose hopes to further strengthen the bridge that connects the accomplishments of the past years to the new challenges that the Alliance will face at the turn of the century.

Rose earned a B.S. degree in psychology in 1971 from the University of Santo Tomas, in her birthplace, Manila, Philippines. She graduated magna cum laude and was presented with award for Most Outstanding Student for Academic Excellence.

In 1977, Rose finished her M.A. degree in clinical psychology also at the University of Santo Tomas. She received the highest honors for her thesis which compared the personality characteristics of sighted and visually-impaired adolescents, a topic she developed while working as a psychologist for the visually impaired at the Dept. of Education and Culture in the Philippines. She hopes to eventually complete her Ph.D. degree in industrial psychology.

Romero

During her career, Rose has worked for a conglomerate in the Philippines as a personnel supervisor in charge of recruitment and testing, and as a training officer doing manpower planning. She later worked in a U.N. subsidiary in New York before becoming a full-time mom.

Rose's involvement with the WVSMA Alliance started a year after she moved to Raleigh County in 1986. She has served as president of the Raleigh County Medical Society Alliance, and is currently parliamentarian.

Rose created the "wall-hanging" calendar for members of the RCMSA, which has become a major fund-raising project. She has helped promote the Alliance's health projects by inviting doctors to speak to junior high and high school students about topics such as the negative effects of the media, substance abuse, domestic violence and teen pregnancy. In addition, Rose has served as a resource person for pre-schoolers on self-esteem and conflict resolution, and on the state level has held the positions of southeast regional director, vice president and president-elect.

The secretary and member of the board of directors for the Women's Resource Center in Beckley, Rose has assisted several community organizations with projects including the United Way of Southern West Virginia, St. Francis de Sales School/Church and the YMCA.

Rose and her husband, Dr. Jose "Joe" Romero, an emergency medicine physician at Raleigh General Hospital, are the proud parents of three daughters.

Rose and the other new Alliance officers will be given the oath of office by AMA president Susan Paddack at the conclusion of the Second Session of the WVSMAA House of Delegates. Jerry Crites, current WVSMAA president, will preside over the meeting, and Jeanny Kalaycioglu, president of the SMA Auxiliary, and several state presidents will be among the guests at this year's meeting.

Special Notice

The reception honoring the new WVSMA President Dr. Phillip R. Stevens, the new Alliance President Rose Romero, and all of the new WVSMA and WVSMAA officers, will take place on the Colonial Terrace as soon as the Second Session of the WVSMA House of Delegates concludes around 12:30 p.m. on Saturday, Aug. 28.

The time of this reception has been moved forward from late afternoon to shorten the length of the meeting and make it easier for participants to return home. Broadway performer Mark McVey will entertain at the reception, which is being hosted by the Cabell County Medical Society.

First General Session to feature three lectures on patient care issues, discussion on public health

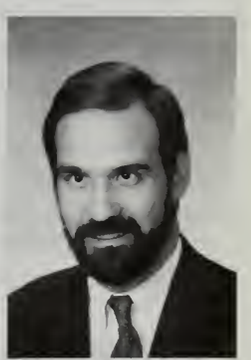
"Readiness to Change, a Partnership with Patients" is the title of the lecture which will kickoff this year's First General Session at the WVSMA's Annual Meeting at The Greenbrier. This lecture will be presented at 8:30 a.m. on Thursday, Aug. 26 by Joseph B. Selby, M.D., medical director of clinical operations at the Clark K. Sleeth Family Practice Center at WVU in Morgantown.

Following Dr. Selby's lecture, Rhonda Lee Travaglino-Parda, M.D., of Plastic Surgery Inc. in Wheeling, will discuss *"New Approaches in the Management of Diabetic Foot Ulcers."* After a brief break, this session will continue with a lecture entitled *"Communication and Disease Management"* by Steven A. Smith, M.D., a consultant at the Mayo Clinic. The fourth and final presentation will then be delivered by Henry G. Taylor, M.D., M.P.H., commissioner of the WV Bureau for Public Health. Dr. Taylor's lecture is entitled *"What Goes Around Comes Around: Public Health 1900-2000."*

Selby

Travaglino-Parda

Smith


Taylor

This First Session and all of the scientific sessions at this year's WVSMA Annual Meeting will take place in the Chesapeake Room and all of the exhibits will be set up next door in the Colonial Hall on the first floor of The Greenbrier.

Additional details about this year's WVSMA Annual Meeting can be found in this General News Section as well as on pages 190-202, or you may phone the WVSMA at (304) 925-0342.

Speakers Highlighted

Dr. Selby obtained a B.S. degree from the College of Business and Public Administration at the University of Maryland in College Park, Md. in 1971. He then worked as a production manager at Los Hermanos Workshop and as a project supervisor for College Park Contractors in College Park, Md.

From 1975-78, Dr. Selby was a journeyman finisher and foreman in Washington, D.C., and Fairbanks, Alaska. He then returned to College Park where became the co-owner of a concrete

company and later opened his own contracting business.

While in the contracting business, Dr. Selby studied chemistry at Prince George's Community College and the University of Maryland. He was accepted into medical school at West Virginia University in 1986 and graduated in May 1990.

In 1990, Dr. Selby was the Burroughs-Wellcome Family Practice Resident Scholar at the WVU School of Medicine and he served as chief resident in psychiatry from 1994-95. Since 1995, Dr. Selby has been an assistant professor and director of behavioral medicine in the Dept. of Family Medicine at WVU. He also currently serves as medical director of clinical operations for the Clark K. Sleeth Family Practice Center at WVU and is compliance officer for University Health Associates in Morgantown.

Dr. Selby is board certified in psychiatry/neurology and family medicine. He is the president of the Monongalia County Medical Society and recently served as the WVSMA's alternate delegate for the Young Physician Section at the AMA's Annual Meeting.

Dr. Travaglino-Parda received her M.D. degree from the Medical College of Ohio in Toledo in 1985. She did her residency in general surgery at the Cleveland Clinic Foundation and completed specialty training in plastic surgery at Georgetown University Medical Center in Washington, D.C.

From 1993-98, Dr. Travaglino-Parda served as chief of plastic surgery for the Surgical Service at the Department of Veterans Affairs Medical Center in Washington, D.C., and as an assistant professor of plastic surgery at Georgetown University Medical Center. She recently relocated to Wheeling, where she is in private practice with Plastic Surgery, Inc., and serves as physician-director of the Center for Wound Care of Wheeling Hospital.

Certified by the American Board of Plastic Surgery and the National Board of Medical Examiners, Dr. Travaglino-Parda has written articles for the *Annals of Plastic Surgery* and the *Journal of Clinical Oncology*.

Dr. Smith is a consultant at the Mayo Clinic where he holds joint appointments in the Divisions of Endocrinology, Nutrition, and Metabolism and Health Services Evaluation. He is also an assistant professor of medicine in the Mayo Medical School and chair of the Diabetes Core Group.

Dr. Smith's clinical and research interests include the psychology of diabetes, measurements of satisfaction and health status, systems health care delivery for people with diabetes to include the relationship between specialists and generalists, and information management and the development and use of the Diabetes Electronic Management System.

Dr. Taylor received his undergraduate degree from Haverford College and then spent a year in Nepal on a National Geographic Project studying temple monkeys. He graduated from Harvard Medical School and completed his internal medicine residency at the Francis Scott Key Medical Center at Johns Hopkins University.

A West Virginian by choice, Dr. Taylor and his wife, Nancyellen Brennan, a family nurse practitioner, came to West Virginia in 1982. They helped establish Pendleton Community Care, one of 13 national demonstration sites for Community Oriented Primary Care, where he spent 13 years as a "modern country doctor" practicing internal medicine without a hospital.

Dr. Taylor became involved with the WV Public Health Advisory Council and stimulated discussion of a masters in public health "without walls" for West Virginia. As a result of this, he left the clinical practice to study for his M.P.H. at Johns Hopkins School of Public Health. He was recruited from Johns Hopkins back to West Virginia to serve as the commissioner of the Bureau for Public Health and continue his interest in helping people in communities identify and address their own health issues.

Medical Assurance retains top rating from A. M. Best

A. M. Best has again awarded Medical Assurance, the WVSMA's endorsed medical liability insurer, a rating of "A" (Excellent), the highest rating available to an insurance company group specializing in medical professional liability insurance. Best cited the company's "excellent profitability, strong capitalization and leadership position in the U.S. malpractice market."

Medical Assurance's Chairman and President A. Derrill Crowe, M.D., stated that West Virginia physicians should be particularly aware of the ultimate consequences of insurers selling coverage at artificially low premiums. He warns physicians about the dangers of forgetting the hard lessons learned when PIE and other companies were declared insolvent.

"Given the three high profile insolvencies in the medical malpractice industry in the past two years, ratings and financial stability should be a real concern for anyone making an informed decision about their malpractice coverage," said Dr. Crowe. "Best's recognition of our leadership position in the industry underscores our ability to make, and keep, long-term promises to our insureds."

In its rating report, Best also noted the company's high policyholder retention rate is supported by a commitment to its insureds through risk management and aggressive claims management, both of which lead to excellent loss experience." Best cited these factors and others in also assigning a "Stable" rating outlook to the company.

For more information about Medical Assurance, phone (304) 346-8228 or (800) 331-6298.

Imaging patients with RLQ pain, cardiac news, bio-terrorism, lung cancer topics for Second Session

This year's Second General Session at the WVSMA's Annual Meeting at The Greenbrier will begin with a lecture entitled *"Radiology Update: Imaging of the Patient with RLQ Pain,"* by Jack K. McLarney, M.D., chief of radiology at Evans Army Community Hospital in Fort Carson, Colo. This session is scheduled to start at 9 a.m. on Friday, Aug. 27.

The other lectures which are planned for this session are: *"Cardiac News,"* by William E. Noble, M.D., F.A.C.C., clinical professor of medicine at the WVU School of Medicine; *"Responding to Bio-Terrorism,"* by LTC Theodore J. Cieslak, M.D., chief of field operations at the U.S. Army Medical Research Institute of Infectious Diseases at Ft. Detrick, Md.; and *"Interventional Bronchology: Newer Procedures in the Diagnosis and Treatment of Lung Cancer,"* by Francis Lee, M.D., F.C.C.P., medical director of pulmonary services at Marietta Memorial Hospital in Marietta, Ohio.

This session and all of the scientific sessions at this year's WVSMA Annual Meeting will take place in the Chesapeake Room and all of the exhibits will be located next door in Colonial Hall.

For registration and other information about this year's WVSMA Annual Meeting, please turn to pages 190-202 or phone the WVSMA at (304) 925-0342.

McLarney

Noble

Cieslak

Lee

Speakers highlighted

Dr. McLarney was born in New York City and his family lived in Laos, the Philippines, Afghanistan and Brazil while he was growing up because of his father's work with the U.S. Dept. of State.

In 1977, Dr. McLarney's family returned to the U.S. and moved to Northern Virginia where he attended high school. He graduated from Johns Hopkins University in 1985 with a B.A. degree in political economy and then attended medical school at the University of Virginia in Charlottesville.

After graduating from medical school in 1989, Dr. McLarney completed an internship in obstetrics/gynecology at Walter Reed Army Medical Center in Washington, D.C., and did his residency in radiology at Brooke Army Medical Center in San Antonio, Texas. In 1994, Dr. McLarney became a staff radiologist with the Dept. of Radiology for the U.S. Army Medical Hospital in Heidelberg, Germany, where he was named chief of the Radiology Dept. the following year.

For the past two years, Dr. McLarney has been assigned to the Armed Forces Institute of Pathology in Washington, D.C., where he has been responsible for the sections of gastrointestinal and genitourinary radiology. The AFIP instructs radiologists in radiology-pathology correlation through a six-week course. This course is attended each year by over 1,200 radiogists from the U.S. and 20 foreign countries.

Last month, Dr. McLarney relocated to Colorado Springs, Colo., to become chief of the Radiology Dept. at Evans Army Community Hospital.

Dr. Noble is a Pennsylvania native who received his M.D. degree from the University of Pittsburgh School of Medicine in 1972. He completed his internship and residency in internal medicine at Presbyterian University Hospital in Pittsburgh, and then completed a cardiology fellowship at Allegheny General Hospital in 1977.

A cardiologist in Wheeling, Dr. Noble serves as chief of cardiology and as medical director of the Cardiovascular Institute and Non-Invasive Services at Ohio Valley Medical Center. He also is on the staffs of Wheeling Hospital, East Ohio Regional Hospital, Reynolds Memorial Hospital and Bellaire City Hospital.

Since 1986, Dr. Noble has been a clinical professor of medicine at the West Virginia University School of Medicine. A fellow of the American College of Cardiology, Dr. Noble is a past president of the Ohio County Medical Society and is the past chairman of the Wheeling Area CME Consortium.

Dr. Cieslak received his B.S. degree in chemistry and his M.D. degree from Ohio State University before completing a residency in pediatrics at the Baylor College of Medicine in Houston. He served as a practicing pediatrician for five years at Ft. Hood, Texas and Landstuhl, Germany before serving a fellowship in pediatric infectious diseases at Walter Reed Army Medical Center.

During his fellowship, Dr. Cieslak's research interests involved pathogenesis and typing mechanisms related to coagulase-negative staphylococci. After a tour as the infectious disease consultant at Brooke Army Medical Center in San Antonio, Dr. Cieslk was appointed chief of field operations at the U.S. Army Medical Research Institute of Infectious Diseases at Ft. Detrick, Md.

In this position, Dr. Cieslak is one of our nation's experts in biowarfare and bioterrorism defense. He has lectured widely on these topics and regularly serves as a consultant on these matters to the Department of Defense, as well as to the CIA, FBI, various State Health Departments, and a myriad of other organizations.

Dr. Cieslak is board-certified in pediatric, infectious diseases and tropical medicine. He holds the rank of lieutenant and is a military flight surgeon.

Dr. Lee was born in Singapore and received his M.B., B.S. degree from the National University of Singapore in 1984, where he also completed postgraduate studies in medicine to earn a master of medicine degree in internal medicine.

From 1989-1992, Dr. Lee completed advanced training in respiratory medicine at Tan Tock Seng Hospital in Singapore. During this time, he also completed a postdoctoral fellowship in therapeutic and diagnostic bronchology at the Cleveland Clinic Foundation.

From 1992-95, Dr. Lee served as a consultant at Tan Tock Seng Hospital where he worked for the Singapore government to set up a program to help prevent and treat lung cancer in the country. In 1995, Dr. Lee returned to the United States to join the Cleveland Clinic. He practiced pulmonary medicine at the Cleveland Clinic until last year when he accepted his current position as medical director of pulmonary services at Marietta Memorial Hospital in Marietta, Ohio. In this position, he is responsible for the sections of Interventional Bronchology, Pulmonary Rehabilitation, the Pulmonary Function Lab and the Sleep Lab at the hospital.

Dr. Lee has been a fellow of the American College of Chest Physicians since 1993. He is board certified in internal medicine and is board eligible for pulmonary medicine. He is a noted researcher who has lectured extensively in the U.S. and abroad.

Awards highlight ACP-ASIM Meeting

Several West Virginia internists were honored at the annual meeting of the West Virginia Chapter of the American College of Physicians-American Society of Internal Medicine, which took place at Lakeview Resort and Conference Center, May 21-23.

The Laureate Award was presented to Mabel Stevenson, M.D., F.A.C.P., and Melanie Fisher, M.D., F.A.C.P., in honor of their professional accomplishments and contributions to the ACP-ASIM. They received the Laureate medallion and join hundreds of other highly qualified internists throughout the United States who have received this prestigious honor through their state chapters.

William C. Revercomb, Jr., M.D., received the Distinguished Internist Award in recognition of his provision of high quality medical care provided to patients of the Charleston area for over 41 years. This award is provided annually to the West Virginia internist who has contributed to the betterment of his/her community as a valued professional, and who has been recognized by his/her colleagues as representing a strong role model for other physicians.

For the past several years, a prominent feature of the WV Chapter meeting has been the Associates Program. This year, over 40 residents from the four internal medicine teaching programs presented papers.

Winners in the four clinical categories included:

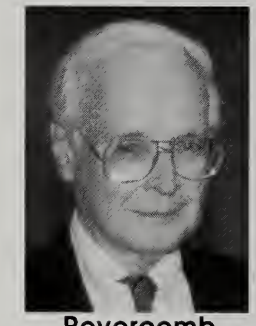
Taha Ahmad, M.D. (WVU)
"Acyclovir Resistant H. Simplex Karatoconjuntivitis in an AIDS Patient;"

Jabin Janoo, M.D. (WVU)
"An Unusual Presentation of Thrombocytopenic Thrombotic Purpura/ Hemolytic Uremic Syndrome;"

Mona Awad, M.D. (WVU)
"Recurrent Respiratory Papillomatosis with Malignant Degeneration;" and

Fisher

Stevenson



Revercomb

Khakoo

Mubarik Khan, M.D. (MU)
"Predictors of Negative Cardiac Catheterization"

The overall winner was Aamer Rahman, M.D. (WVU), for his paper *"Werneke's Encephalopathy at WVUH."* Dr. Rahman will present his paper at the Annual Session of the ACP-ASIM in Philadelphia next spring. The team of residents from Ohio Valley Medical Center in Wheeling won the Medical Knowledge Challenge Competition. This team will also represent the WV Chapter in the national competition.

During the annual meeting of the ACP-ASIM earlier this spring, the WV Chapter received the prestigious Evergreen Award, in recognition of its successful Associates' Programs. Since its inception in 1993, this marks the third time the WV Chapter has won the Evergreen Award.

In other events at the meeting, Rashida Khakoo, M.D., F.A.C.P., chief of the Infectious Diseases Section in the Dept. of Medicine at WVU, was installed as the new governor for the WV Chapter. Dr. Khakoo succeeds Derrick L. Latos, M.D., F.A.C.P., who completed his four-year term this spring.

Annual fund-raising seminar for Health Access very successful

The Sixth Annual Seminar in Pathology and Cytopathology, sponsored by the United Hospital Center of Clarksburg, was held at the Sheraton Station Square Hotel in Pittsburgh from May 1-4 to raise funds for Health Access, a free clinic in Clarksburg. This year, 179 pathologists and cytologists from the U.S. and Canada, as well as 11 speakers participated in the seminar.

Since the first annual seminar in 1994, about 700 pathologists from the U.S., Canada and Europe have attended this event. About half of this year's attendees were repeat participants. This year, $30,000 was donated to Health Access, and since 1994, over $130,000 has been raised for this charity. The seminars were organized and conducted by Chinmay K. Datta, M.D., Ph.D., a pathologist at the UHC. Bruce C. Carter, CEO and president of the UHC, spoke to the participants about the need for fund-raising for Health Access. Other individuals who helped with this year's seminar were Sam Ellis, UHC Auxiliary volunteer; Joanne Parks, lead technologist of the UHC laboratory; Lisa Ashcraft, LIS coordinator of UHC; Suzanne Hornor, director of public relations for UHC; Larry Parks; and Subhra Datta, a member of the board of directors of Health Access.

Participants listen to a lecture during the Sixth Annual Seminar in Pathology and Cytopathology at the Sheraton Station Square Hotel in Pittsburgh.

WVACS Officers

The WV Chapter of the American College of Surgeons met April 29-May 1 at Greenbrier in White Sulphur Springs. Officers and councilors attending the meeting were *(First Row)* Dr. R. C. Shah, president; and Dr. Eric P. Mantz, governor. *(Second Row)* Dr. James H. Morgan III, councilor; Dr. Generoso Duremdes, councilor; Dr. Amabile Milano, councilor; Dr. David A. Kappel, state trauma chairman; and Dr. Robert Gustafson, second vice president. *(Third Row)* Dr. Kyle F. Fort, councilor; Dr. Roger E. King, secretary/treasurer; Dr. David A. Denning, state cancer liaison chairman; Dr. R. Sam Oliver, councilor; Dr. S. Willis Trammell, past president; and Dr. E. Phillips Polack, president-elect.

WVU ophthalmology conference set for September 24-25

The WVU Dept. of Ophthalmology will conduct its 20th Annual Clinical Ophthalmology Conference at the Erickson Alumni Center from Sept. 24-25.

Speakers include Drs. Herbert Kaufman, Michael Marmor and Susan Lewallen.

For more information, phone Nancy Gover at (304) 293-1987.

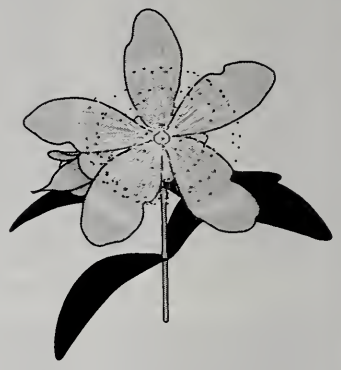
Dr. Singh to address Second Session of HOD

Sarjit Singh, M.D., president of the WV Board of Medicine, will make a presentation entitled *"WV Board of Medicine: Friend Not Foe"* on Saturday morning August 28 during Second Session of the House of Delegates at the WVSMA's Annual Meeting at The Greenbrier.

132nd Annual Meeting Preliminary Program

Pre-Convention Meetings

Tuesday August 24, 1999



6 p.m. WVSMA Executive Committee Dinner/Business Meeting

Convention Program

Wednesday August 25, 1999

8:30 - 4 p.m. Registration/Exhibit Setup - **Colonial Hall**

9 a.m. WVSMA Council Meeting

11:30 a.m. Executive Committee/Council - Component Society and Specialty Society Presidents', Visiting State Presidents and 50-year Graduate Luncheon

1:30 - 4:30 p.m. **First Session House of Delegates, Chesapeake Room**

1999 WVSMA Award Presentations

Thomas L. Harris Address, *"From Weekend Warriors to Professionals: Special Concerns Treating Athletes"* William A. Hazel, Jr., MD

Edmund B. Flink Address, *"Fever - Old and New"* Rashida A. Khakoo, MD

Constitution & ByLaws

Introduction of Resolutions

Annoucement of 1999-2000 Candidates for Office

6:30 - 7:30 p.m. Presidential Reception, *Hosted by Parkersburg Academy of Medicine*

Thursday, August 26, 1999

7 - 8:30 a.m. Medical Education Committee Breakfast Meeting

8 a.m. - 2 p.m. Registration/Exhibit Visitation - **Colonial Hall**

8:30 - Noon **FIRST GENERAL SESSION - Chesapeake Room**

"Readiness to Change, a Partnership with Patients" Joseph B. Selby, MD

"New Approaches in the Management of Diabetic Foot Ulcers" Rhonda Lee Travaglino Parda, MD

"Communication and Disease Management" Steven A. Smith, MD, Mayo Clinic

"What Goes Around Comes Around: Public Health 1900-2000" Henry G. Taylor, MD, MPH, Bureau of Public Health

Noon - 1:30 p.m. **Lunch & Learn,** *"Medicare Fraud in Cyberspace"* Craig Curry, Supervisor of the Fraud Investigation Unit at Nationwide Medicare

1:30 p.m. Committee on Resolutions, Open/Closed Session

2 p.m. Golf, Tennis, and Volleyball Tournaments

6:30 - 7:30 p.m. Reception, *Hosted by Medical Assurance of WV and Acordia of WV*

Friday, August 27, 1999

7 - 8:30 a.m.	WVSMA Section on Surgery
8 a.m. - 4:30 p.m.	WVSMA Registration - **Colonial Hall**
9 a.m. - Noon	**SECOND GENERAL SESSION - Chesapeake Room**
	"Radiology Update: Imaging of the Patient with RLQ Pain" John K. McLarney, MD
	"Cardiac News" William E. Noble, MD, FACC
	"Responding to Bio-Terrorism," Lt. Col. Ted Cieslak, MD
	"Interventional Brochology: Newer Procedures in the Diagnosis and Treatment of Lung Cancer" Francis Lee, MD, FCCP
Noon - 1:30 p.m	**Lunch & Learn,** *"Impacting the Legislative Process"* Richard Deem, Vice President for Government Affairs, AMA
1:30 - 2:30 p.m.	WESPAC Meeting
Noon - 1:30 p.m.	WVSMA Cancer Committee Meeting
Noon - 4 p.m.	WV Psychiatric Association Meeting, *"Ethical Changes of Managed Care"* Jeremy Lazarus, MD
12:30 - 2:30 p.m.	WVSMA Publications Committee
2 - 5 p.m.	*"Your Practice: Prescription for the Future,"* Medical Assurance Loss Control Seminar
2 - 5 p.m.	WV Medical Institute Board of Trustees Meeting
4:30 - 5:30 p.m.	Scientific & Educational Sessions Committee Meeting
6 - 7 p.m.	Reception, *Hosted by West Virginia University and Marshall University Schools of Medicine*
9 - Midnight	Entertainment, *"Lousisiana's Rockin' Fiddler" and Band,* Wayne Thibodeaux

Saturday, August 28 1999

7:30 - 11 a.m.	WV Radiological Society Meeting
7:30 a.m.	Breakfast Meetings - Times and Locations TBA
8 - 9 a.m.	Delegate Voting Registration, Chesapeake Bay and Foyer **(Voting will close at 9 a.m.)**
9:15 a.m.	**WVSMA Second Session House of Delegates, Chesapeake Room**
	AMA Presidential Address, *"The Changing Face of American Medicine"* Thomas Reardon
	Business Meeting
	Resolutions
	Announcement of Election Results
	WVSMA Presidential Address - David W. Avery, M.D., WVSMA President, *"Follow the Yellow Brick Road"*
	Oath of Office and Presidential Address, *"Healthcare in the 90s, The Gathering Storm"* Phillip R. Stevens, MD
	Adjournment
Immediately following the Second Session House of Delegates	Reception honoring newly installed officers of the WVSMA and Alliance

The West Virginia State Medical Association

132nd Annual Meeting

August 25-28, 1999

THE Greenbrier®
WHITE SULPHUR SPRINGS
WEST VIRGINIA 24986

- Scientific Sessions
- Specialty Meetings
- Two Lunch & Learn Programs
- Entertainment
- Tournaments
- Exhibits
- Receptions
- Enjoy the amenities and wonderful atmosphere of The Greenbrier!

Registration Form

Name _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

Specialty _____

Please detach and mail with payment to:
WVSMA, P.O. Box 4106, Charleston, WV 25364.

Would you like to register over the phone? Just call us at (304) 925-0342. Please have your Visa or MasterCard ready.

Register online at www.wvsma.com. Click on "upcoming meetings"!!

Fax us your registration form at (304) 925-0345.

Payment by: ❒ Check ❒ MasterCard ❒ VISA

Card Number _____

Expiration Date _____

Signature _____

Registration Fees —

❒	WVSMA Member	$125
❒	Non-member	$175

Lunch & Learn — Thursday, August 26, 1999
"Evaluation & Management Guidelines for Fraud and Abuse"

❒	WVSMA Member (With CME)	$50 (each session)
❒	All others (No CME credit)	$35 (each session)

Lunch & Learn — Friday, August 27, 1999
"Impacting the Legislative Process"

❒	WVSMA Member (With CME)	$50 (each session)
❒	All others (No CME credit)	$35 (each session)

Total Due: _____

Cancellation of registration should be in writing. If a cancellation is postmarked or phoned to the WVSMA before August 1, 1999, the paid registration fee will be refunded less a $50 administrative charge. For cancellations after August 1, 1999, no refunds will be made.

WVSMA Alliance Preliminary Program

August 26 - 28, 1999
The Greenbrier

Thursday, August 27

8:30 a.m. - 3 p.m.	Registration, *Exhibit Center Foyer*
Noon	Lunch & Learn, "Evaluation and Management Guidelines," *Hayes Room*
2 p.m. - 3 p.m.	Pre-Convention Board Meeting - All members of the 1998-99 Board must attend. *Wilson Room*
6:30 p.m. - 7:30 p.m.	Reception, Hosted by Acordia of WV and Medical Assurance of WV, *Colonial Lounge and Terrace*

Friday, August 28

8 a.m. - 9 a.m.	Registration, *Outside Filmore-Van Buren Room*
9:15 a.m.	**First Session House of Delegates,** *Jerry Crites, WVSMAA President, presiding, Filmore Room*
Noon	**President's Board Luncheon,** *Chesapeake Bay (Invitation Only)*
1:30 p.m.	**Second Session House of Delegates,** *Jerry Crites,presiding, Filmore Room*
6 p.m. - 7 p.m.	Reception, Hosted by WVU and MU Schools of Medicine, *Cameo Ballroom*
8 p.m.	Entertainment, Waylon Thibodeaux, *Chesapeake Hall*

Saturday, August 29

8 a.m.	Past President's Breakfast (Invitation Only), *Washington Room*
8:30 a.m. - 9:30 a.m.	Registration, *Outside Filmore Room*
9:45 a.m.	Post-Board Meeting, *Rose Romero, WVSMAA President, presiding*
1 p.m.	Installation of WVSMA Officers, *Chesapeake Hall*
1:30 p.m.	WVSMA Presidential Address, *Phillip R. Stevens, M.D.*
TBA	Reception honoring newly installed Officers of WVSMA and Alliance Hosted by Cabell County Medical Society, *Colonial Lounge and Terrace*

1998 WVSMAA ANNUAL MEETING - REGISTRATION FORM

Name _____

Address _____

City, State, Zip _____ Phone Number _____

Please list county, state offices you've previously held _____

☐ **My $5 registration fee, cash or check, made payable to the WVSMAA, is enclosed.**

MAIL TO: Christina Dixon, WVSMAA, PO Box 4106, Charleston, WV 25364

Although you can register on-site, name tags will only be pre-printed for those who pre-register.
For more information, call Christina at (800) 257-4747.

Lunch & Learn at WVSMA's Annual Meeting, Thursday, August 26 and Friday, August 27.

"Evaluation and Management Guidelines for Fraud and Abuse"
Craig Curry, Supervisor of the Fraud Investigation Unit and Nationwide Medicare
Thursday, August 26
Noon - 1:30 p.m.

Join us in August

"Impacting the Legislative Process"
Ms. Tracy Sinnott, American Medial Political Action Committee (AMPAC)
Friday, August 27
Noon - 1:30 p.m.

WAYLON THIBODEAUX

"Louisiana's Rockin' Fiddler"

Celebrate Annual Meeting

Cajun Style

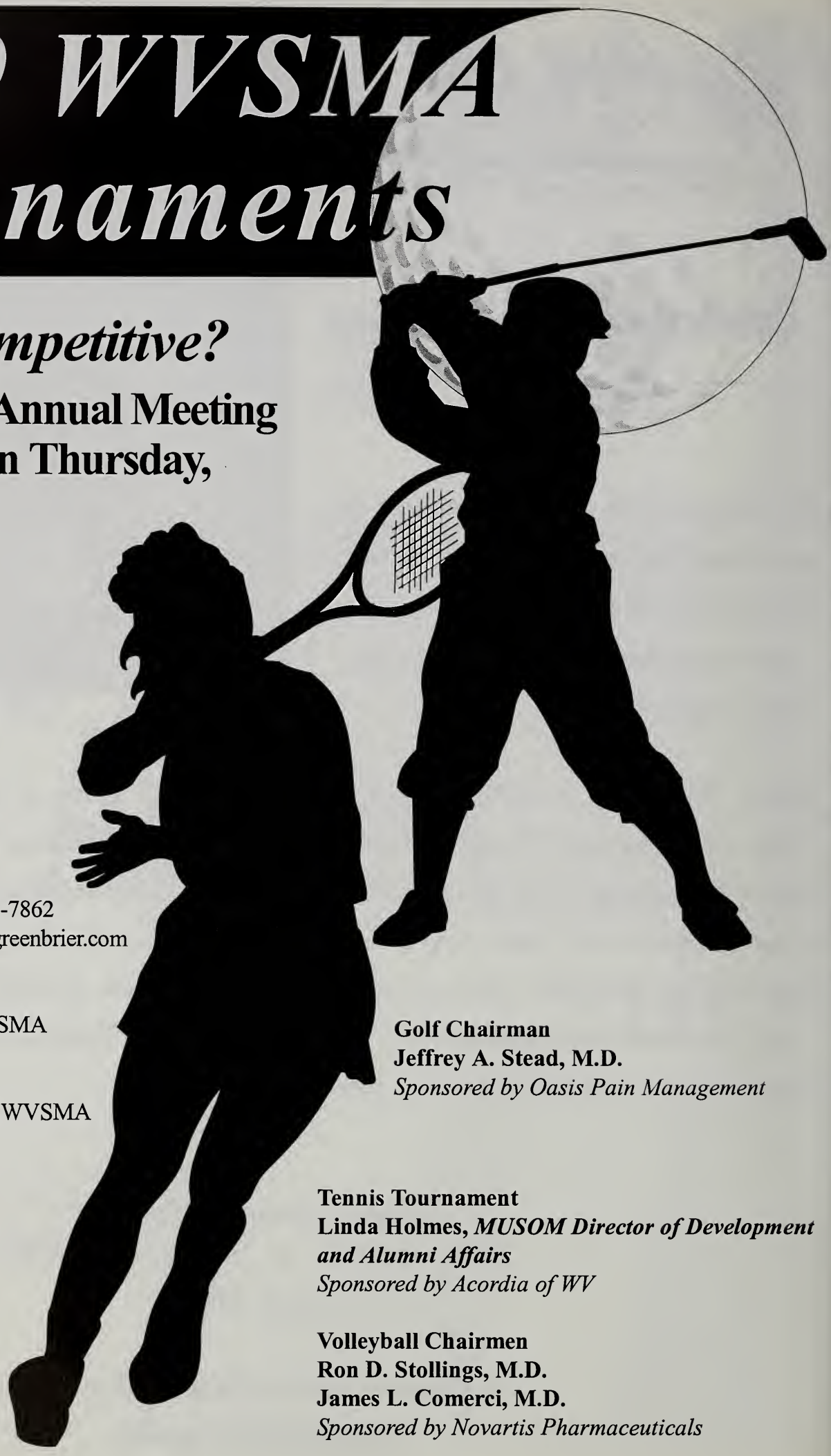
Don't miss out on the music, food, and fun at this year's Annual Meeting. The Chesapeake Room at The Greenbrier will be the setting for a special casual evening of entertainment featuring Cajun musician Waylon Thibodeaux.

Waylon Thibodeaux is a french-speaking Cajun, who performs a variety of Louisiana, Cajun and Zydeco music. Known as *Louisiana's Rockin' Fiddler*, Thibodeaux began playing professionally at age 13 and has performed with nationally and internationally renowned musicians and groups such as Tony Orlando, Jo-El Sonnier, Jimmy C. Newman, BeauSoleil and Evangeline, and an artist with Mardi Gras Records. In addition to playing at festivals and special events in the U.S. and Canada, Thibodeaux is a popular act at La Strada's Nightclub in New Orleans.

Chesapeake Room, The Greenbrier
Friday, August 27 • 9:00 p.m. - Midnight
Casual Attire

Entertainment hosted by Acordia of West Virginia
A cash bar will be available

1999 WVSMA Tournaments



Feeling Competitive?

Join us for the Annual Meeting Tournaments on Thursday, August 26!

To Register for:

- **Golf** Please call (304) 536-7862 or e-mail JohannaHonaker@greenbrier.com for golf starting times.
- **Tennis** Sign up at the WVSMA Registration Desk
- **Volleyball** Sign up at the WVSMA Registration Desk

Golf Chairman
Jeffrey A. Stead, M.D.
Sponsored by Oasis Pain Management

Tennis Tournament
Linda Holmes, *MUSOM Director of Development and Alumni Affairs*
Sponsored by Acordia of WV

Volleyball Chairmen
Ron D. Stollings, M.D.
James L. Comerci, M.D.
Sponsored by Novartis Pharmaceuticals

ACTIVITIES REGISTRATION

132nd Annual Meeting
August 25 - August 28, 1999
The Greenbrier

Copy this form for additional registrants

WVSMA GOLF TOURNAMENT
Thursday, August 26, 1999
"Old White" Course

Tee times will be available from Noon - 2 p.m. Thursday, August 26. Arrangements with tee times and scheduling are made directly with The Greenbrier by calling (304) 536-7862. If you are not able to make appropriate arrangements, call the WVSMA office at (800) 257-4747 or submit the following information by August 17. Trophies will be given for low net, low net runner-up, low gross, low gross runner-up, closest to the pin and longest drive. Trophies will be awarded during the 10 a.m. break in the Exhibit Hall Friday, August 27.

Name _____

Phone number _____

WVSMA TENNIS TOURNAMENT
Thursday, August 26, 1999
2 p.m.
Hilltop Courts

Please register me for the Tennis Tournament Thursday, August 27. Pairings will be made at the tennis court. Spouses and other family members are encouraged to participate. Round Robin tournaments for men's doubles, women's singles, and mixed doubles will be played. Men's doubles and women's singles will be played first. Trophies will be awarded for 1st and 2nd place Men's/Women's doubles, 1st and 2nd place Women's/Men's singles and will be awarded during the 10 a.m. break Friday, August 27 in the Exhibit Hall. • Note, a sign-up sheet for the tennis tournament will also be available at the WVSMA Registration Desk.

Name _____

Phone number _____

WVSMA VOLLEYBALL TOURNAMENT
Thursday, August 26, 1999
2 p.m.
Court located above Hilltop Courts

Please register me for the Volleyball Tournament. Spouses and other family members are encouraged to attend. T-shirts, compliments of Novartis Pharmaceuticals, will be provided. A sign-up sheet for the Volleyball Tournament will also be available at the Registration Desk located in the Exhibit Hall.

Name _____

Phone number _____

Return to: Christina R. Dixon, Public Relations Director, WV State Medical Association, P.O. Box 4106, Charleston, WV 25364. Telephone: (304) 925-0342 Fax: (304) 925-0345.

If you don't play golf, you might want to start!

RMI, Ltd. is sponsoring a "Hole-In-One" on Hole #3 of the "Old White" course. The contest is being held in conjunction with the WVSMA Golf Tournament, sponsored by Oasis Pain Management, Thursday, August 26 from Noon - 2 p.m.

The prize is Fifteen Thousand Dollars... yes, you read it correctly-

$15,000.!!

To schedule a tee time for the WVSMA Golf Tournament, please call The Greenbrier at (304) 536-7862.

Join us at The Greenbrier Saturday, August 29 at 7 a.m. for a

"Fun Run-Walk"

Hosted by Medical Assurance of West Virginia

As part of the West Virginia State Medical Association's 132nd Annual Meeting at The Greenbrier, August 25-28, Medical Assurance is hosting its first ever "Fun Run-Walk" Saturday, August 28 at 7 a.m. The 2-mile run/walk is an excellent way to work off some calories and get some exercise before you start your day.

Medical Assurance will provide hats to all the participants and will offer prizes for best dressed, best "hat hair," fastest female, fastest male, best dressed, oldest participants and other flattering categories! Fruit, granola bars, coffee, fruit juices and water will be served starting at 6:30 a.m.

Plan now to attend this fun and healthy event at The Greenbrier. All WVSMA members, spouses, children, and exhibitors are encouraged to participate. Look for more information in the WVSMA Preliminary Program. Sign up sheets will be located at the WVSMA Registration Desk. For more information, please see Kathi Burton at Medical Assurance at their Exhibit Booth.

WVSMA Annual Meeting Exhibitors

We would like to welcome the following exhibitors to the WVSMA's 132nd Annual Meeting and we hope they are pleased with their new display areas in Colonial Hall:

BOOTH #1
WV Healthy Kids' Coalition
Judi Almond

BOOTH #2
WV Board of Medicine
Sarjit Singh, M.D.

BOOTH #3
West Virginia University, Charleston Division
Guy Anderson

BOOTH #4
West Virginia University School of Medicine, Alumni Affairs
Cecile Calloway, Anne Sarmiento, Gina Slaugenhoup, Lynda Nine

BOOTH #5
Marshall University School of Medicine
Beth Hammers, Linda Holmes

BOOTH #6
Family Medicine Foundation of WV
Chris Ferrell

BOOTH #7
Pfizer/Roering
Kurt Minne'

BOOTH #8
SmithKline Beecham Pharmaceuticals

BOOTH #9
GlaxoWellcome
Gary Browning, Roger Reed, David Linkous, Linda Richmond, Ken Ewing

BOOTH #10
Wyeth Labs
Marlon Gutierrez, Tim Atchison, Brian Abraham

BOOTHS #11 &12
Medical Assurance of WV
Kathi Burton, Michele Myers, Chuck Ellzey, Steve Brown, Rob Francis, Martin Ennis, Derrill Crowe, M.D.

BOOTHS #13 & 14
Acordia of WV, Inc.
Robert Vass, Tamara Lively, Scott Atkins

BOOTH #15
MetLife Financial Services
Steve Hyer, Johnny Osborne

BOOTH #16
West Virginia State Medical Association Alliance

BOOTH #17
American Dairy Association and Dairy Council Mid East
Dixie Copley

BOOTH #18
WV Bureau for Public Health, Osteoporosis Prevention Education
Kimberly Smith, M.S., C.H.E.S.

BOOTH #19
Nycomed Amersham
Martha S. Wilson

BOOTH #20
Josephthal & Co.
Gary Stewart, Chris Stewart, Steve Taton

BOOTH #21
PrimeOne
Lori Launders, Terra Moyers, Vince Sowards, Martyn Hughes

BOOTH #22
Citynet
Jamie Scott

BOOTH #23
Schering Oncology/Biotech
Diane Hackney Oliver, Tim Grossman

BOOTH #24
U.S. Army Health Care Recruiting
Sergeant First Class Pamela Wincapaw

BOOTH #25
West Virginia Medical Institute
Mark K. Stephens, M.D.,
Becky Cochran, M.S.N., R.N.

BOOTH #26
Bureau for Public Health Division of Recruitment
Melissa Wheeler

BOOTH #27
Division of Rehabilitation Services, Disability Determination
Rae Burdette, Carolynn White, Paul Oliverio, Don Cross

BOOTH #28
Robert C. Byrd Health Sciences Center
Shannon Lehman, Joe Antonini

BOOTH #29
Parke-Davis
Jerri Kaufman, Sherry Stottlemyer, JoAnn Henry

BOOTH #30
Hologic, Inc.
Thomas Harris

BOOTH #31
Rhone-Poulenc
Jamie Whitt, Katie Daniels, Bill Smith

BOOTH #32
Rhone-Poulenc Rorer
Earl Lawson, Michael Ball

BOOTH #33
WV Assistive Technology System
Jeanne Grimm, Colleen Reed

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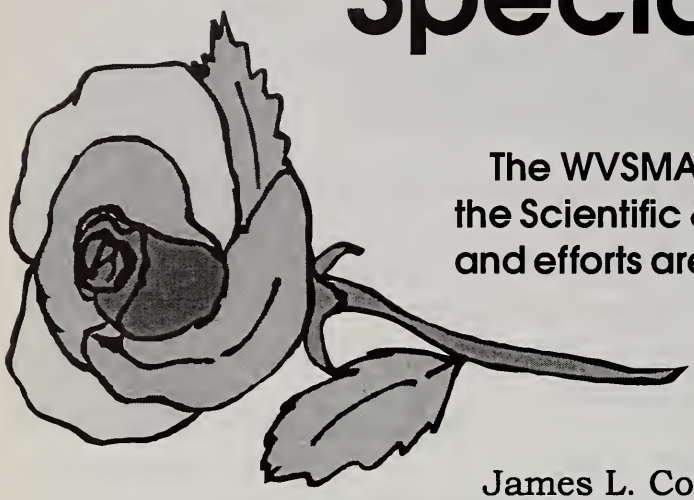

The WVSMA staff would like to recognize the members of the Scientific & Educational Sessions Committee. Your time and efforts are greatly appreciated!

James L. Comerci, M.D., Chairman

Constantino Y. Amores, M.D.
David W. Avery, M.D.
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The WVSMA staff would also like to recognize the following firms, associations and schools for contributing support and educational grants for this year's Annual Meeting:

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Make plans to attend the

WVSMA 2000 Mid-Winter Seminars & Scientific Conferences January 20-23, 2000

Embassy Suites Hotel Charleston, West Virginia

CME & Special Events

Camcare Health Education & Research Institute

"Current Management of Breast Cancer"
Aug. 23, noon, Patrick McGrath, M.D., Robert C. Byrd HSC of WVU, Charleston Division

"10th Annual Respiratory Care Conference"
Sept. 1, 8 a.m., Robert C. Byrd HSC of WVU, Charleston Division

"Diagnosis and Treatment of Back Pain"
Sept. 1, 12:30 p.m., Constantino Y. Amores, M.D., Montgomery General Hospital, Montgomery

"Congenital Heart Disease in Pediatrics"
Sept. 10, noon, John Eckerd, M.D., Logan General Hospital, Logan

"Phase I Trial: Metastic Breast Cancer"
Sept. 13, noon, Brenda Nicholson, M.D., Robert C. Byrd HSC of WVU, Charleston Division

"Wound Care - Part II"
Sept. 15, 6 p.m., Scott Spradlin, D.O., Man Appalachian Regional Hospital, Man

"Treatment of Type I and Type II Diabetes"
Sept. 21, 6:30 p.m., Steven A. Artz, M.D., Roane General Hospital, Spencer

"Colon-Rectal Cancer"
Sept. 27, noon, Richard Pazdur, M.D., Robert C. Byrd HSC of WVU, Charleston Division

Huntington Medical Community Foundation

"Abuse: Survivors and Offenders"
Aug. 26, noon, Megan Mynes, M.A., Pleasant Valley Hospital, Point Pleasant

"Update in Critical Care/Emergency Medicine Symposium - Treatment of Shock/Systemic Inflammatory Response Syndrome"
Sept. 10, 6:30 p.m., David Denning, M.D., Highlands Regional Medical Center, Prestonsburg, Ky.

"Update in Critical Care/Emergency Medicine Symposium - Spider Bites"
Sept. 11, 9 a.m., Robert Walker, M.D., Highlands Regional Medical Center, Prestonsburg, Ky.

"Medical Malpractice: Reducing Risk"
Sept. 22, noon, Kathi Burton, Pleasant Valley Hospital, Point Pleasant

"Care of Traumatic Foot Injuries"
Sept. 23, noon, Jeffrey Shook, M.D., Pleasant Valley Hospital, Point Pleasant

"Osteoporosis"
Sept. 28, 7 p.m., David Jude, M.D., Paul B. Hall Regional Medical Center, Paintsville, Ky.

"Use of Opioids in Chronic Non-Malignant Pain,"
Sept. 29, 6 p.m., Ahmet H. Ozturk, M.D., Appalachian Regional Hospital, South Williamson, Ky.

Marshall University School of Medicine

"MU School of Medicine Alumni Weekend Conference"
Sept. 24, MU Medical Center & Radisson Hotel, Huntington

"Annual Cancer Conference"
Oct. 1, St. Mary's Hospital, Huntington

Robert C. Byrd HSC - Morgantown

"Recent Advances in PET Imaging"
Sept. 10, Robert C. Byrd HSC, Morgantown

"Eighth Annual Fall OB/GYN Women's Health Symposium:Complications and the Complicated Patient"
Sept. 17-19, Nemacolin Woodlands, Farmington, Pa.

"Total Joint Arthroplasty, Current Issues, Concepts and Considerations"
Sept. 24-25, Kiawah Island Resort, Kiawah Island, S.C.

"WV RHEP Faculty Development Day"
Sept. 24-25, Alderson-Broaddus College, Philippi

"20th Annual Clinical Ophthalmology Conference"
Sept. 24-25, Erickson Alumni Center, Morgantown

"Psychosis '99: Preparing for the Millennium"
Sept. 27, Ramada Inn, Morgantown

"25th Annual Hal Wanger Family Medicine Conference"
Sept. 30-Oct. 2, Robert C. Byrd HSC, Morgantown

West Virginia State Medical Association

"WVSMA's Annual Meeting"
Aug. 25-28, The Greenbrier, White Sulphur Springs

Poetry Corner

This Work

these troubled kids
are ocean liners
and we're like
plucky tugs

the best and
only way we have
to move them
from their
course of doom
is to nudge

what we need
is to relax
just a little
and breathe deep
chug chug chug

Charles R. Joy, M.D.

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engines lived,
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tracks, and wheels . . .
B & O - the moment rides.

John Henry McWhorter, M.D.

Plans for Healthy People 2010 outlined at Summit

Governor Cecil Underwood kickoffs the Healthy People 2010 Summit at the Charleston Civic Center on June 24. Also pictured are Alan Holmes, director of the Office of Epidemiology and Health Promotion for the Bureau for Public Health, and Dr. Marshall Kreuter, associate director for Health Promotion Policy and Programs for the Centers for Disease Control and Prevention in Atlanta.

To continue to improve the health and lifestyles of West Virginians, the Healthy People 2010 Summit was conducted at the Charleston Civic Center on June 24. This one-day conference was sponsored by the Healthy West Virginia Coalition, the WV Bureau for Public Health and the State Education Council of West Virginia, to officially kickoff the state's goals as part of the national Healthy People 2010 agenda.

In West Virginia, over 200 objectives, tailored to our own particular health priorities based on state data, will strive to focus resources and drive health prevention strategies for the next ten years.

"While everyone is looking toward the year 2000, in the public health arena we need to be looking to 2010 and beyond in an effort to stay ahead of the curve," said Dr. Henry Taylor, commissioner of the Bureau for Public Health. "Public health issues are much different today than they were 10 years ago, and we certainly expect them to be different 10 years down the road. It is our intention, through the national Healthy People 2010 program, to prepare now for the challenges of tomorrow."

The Healthy People 2010 process, both nationally and on the state level, is a broad public/private partnership. The Healthy West Virginia Coalition, a consortium of health delivery channels and networks, is overseeing the process for our state, working to ensure representation from all potential health delivery systems. The WVSMA is an integral part of the Healthy West Virginia Coalition, which consists of over 350 people from a variety of occupations and walks of life, who are working together to select target health objectives for the next ten years.

In his address at the Healthy People 2010 Summit, Dr. Henry Taylor, commisssioner of the WV Bureau for Public Health, stressed the importance of "*preparing now for the challenges of tomorrow.*"

"Our basic mission is to prevent unnecessary disease and mortality," said Marshall Kreuter, Ph.D., the associate director for Health Promotion Policy at the Centers for Disease Control and Prevention, in his keynote address at the Healthy People 2010 Summit.

In his remarks, Dr. Kreuter proposed decreasing health problems by increasing "social capital," a concept that as social assets increase, public health problems decrease. For example, in communities where adults said in a survey, "Yes, I would intervene" (in a potentially violent situation),

data showed the local level of violence was lower.

According to Dr. Kreuter, this philosophy is also illustrated by study published in the *New England Journal of Medicine* in 1998 entitled *"Children Can't Fly."* This article detailed how child death rates in Harlem, N.Y., were drastically decreased when a group wrote a grant for small safety bars to be placed across the windows so that children could not accidentally fall from upper floors of apartment buildings.

When data from that project was presented to the community, residents became excited and asked, "What else can I do?" Since that time, ten project goals have successfully been accomplished in that formerly resistant community.

Focus areas in the WV Healthy People 2010 document will range from risk reduction to disease prevention, creating healthy and safe communities, improving systems for personal and public health, and increasing access to quality health services. One rapidly-rising health challenge is adverse drug reactions (ADRs).

Dr. Marshall Kreuter, associate director for Health Promotion Policy and Programs for the Center for Disease Control and Prevention in Atlanta, discusses *"social capital,"* a concept that advocates building social assets to decrease public health problems.

According to an article in the April 15, 1998 issue of the *Journal of the American Medical Association*, ADRs may be responsible for more than 100,000 deaths nationwide each year. This would rank ADRs between the fourth and sixth leading cause of death in the U.S.

Dr. Taylor will be discussing various issues concerning Healthy People 2010, as part of his lecture entitled *"What Goes Around Comes Around: Public Health 1900-2000,"* which will be presented at 11 a.m. on Thursday, Aug. 26 during the WVSMA's Annual Meeting at The Greenbrier.

For more information about WV Healthy People 2010, visit the Bureau's website: http://www.wvdhhr.org/bph/hp2010, or contact Cathy Cleland at (304) 558-0644 or cathycleland@wvdhhr.org

Cathy Cleland
Healthy People 2010 Program Manager
Division of Health Promotion
WV Bureau for Public Health
(304) 558-0644

Coalition For A Tobacco-Free West Virginia

The Coalition For a Tobacco-Free West Virginia, in conjunction with the WV Bureau of Public Health, The Centers for Disease Control and Prevention and WV Youth Tobacco Prevention Campaign, announces the 7th Annual WV Tobacco Prevention Campaign Conference, *"Together We Can Make A Difference,"* October 4-5 at Canaan Valley Resort in Davis, WV.

The keynote speaker will be Charles Wolfe, Executive Vice President of American Legacy Foundation.

Topics to be discussed include:
**Framing Tobacco Prevention Messages*
**School Tobacco Policies*
**Creating Media Opportunities*
**Discussing Tobacco Prevention Messages with Legislators*

To register for the meeting call (304) 342-6600.
The registration fee for the meeting is $100 for non-members, $75 for members.
To reserve a room at Canaan Valley Resort, call (800) 622-4121.

Robert C. Byrd Health Sciences Center of West Virginia University News

Rosenbaum Family House dedicated

Cutting the ribbon to the Rosenbaum Family House are *(from left to right)*: Scott Rotruck, president of the Family House board of advisors; Bruce McClymonds, president of WVU Hospitals; Hilda Rosenbaum vice chair of the Family House Advisory Board; and WVU President David C. Hardesty Jr.

The newest building on the WVU campus is named Rosenbaum Family House to honor Morgantown businesswoman Hilda Rosenbaum and her family, who donated $1 million towards construction costs.

Rosenbaum Family House is located next to the hospital and provides housing for the families of adult patients who are being treated at the hospital, and for people from distant locations who need to stay near the hospital for extended outpatient treatment.

Rosenbaum serves on the house's advisory board. Her gift helps WVU Hospitals and the Mary Babb Randolph Cancer Center care for blood and marrow transplant patients, accident victims, heart surgery patients and other individuals who must spend long periods of time in the hospital.

Physicians who are referring patients to WVU for treatment can obtain information about the Rosenbaum Family House by phoning, 1-800-WVU-MARS.

Adolescent risk behavior specialist joins faculty

Stanton

Dr. Bonita F. Stanton, an expert in adolescent risk behavior and AIDS prevention, has been named chair of the Dept. of Pediatrics in the WVU School of Medicine.

Dr. Stanton was formerly vice chair for pediatrics and head of general pediatrics at the School of Medicine, University of Maryland, Baltimore. She also directed the school's Center for Minority Health Research.

"Dr. Stanton is nationally known for combining her medical expertise with a broad understanding of how a child's social and family situation affects his or her health," said Dr. Robert D'Alessandri, vice president for health sciences and dean of medicine at WVU. "We expect her to take a leadership position, not just within our faculty, but as an advocate for the health of every West Virginia child."

UHA names Prescott president

Prescott

Dr. John E. Prescott has been named president of University Health Associates (UHA), the faculty practice of the WVU School of Medicine. He has also been named an associate dean of medicine, responsible for relations between the school and its affiliated health care enterprises, including WVU Hospitals and the West Virginia United Health System.

Dr. Prescott has been serving as interim president of UHA since Jan. 1. "UHA is a service organization," he said. "I look forward to maximizing its contributions to the School of Medicine and to the health of West Virginians."

Dr. Prescott has stepped down as chair of the Department of Emergency Medicine in the WVU School of Medicine.

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Marshall University School of Medicine News

Byrd Center dedication draws full house

Guests, faculty and staff filled the atrium of the Marshall University Medical Center on June 2 for the dedication of the Robert C. Byrd Center for Rural Health. The Center for Rural Health houses a modern learning technology center which will be used to support rural providers, as well as offices for two regional positions of the WV Dept. of Health, a medical library, an auditorum and teleconferencing facilities.

Environmental health focus of annual conference

"Environmental Health in the 21st Century" will be the theme of the continuing medical education conference presented by the MU School of Medicine for annual Alumni Homecoming.

The conference, which is open to all health professionals, will be Sept. 24 in Huntington.

"There's not a time that you turn on the TV or the radio that you don't hear something about the environment and how it impacts health," said Dr. James Becker of Marshall's Department of Family and Community Health. "This weighs heavily on the minds of patients, and they bring it up with every doctor they see. Through this conference, we want to provide general information about environmental health that will be helpful to physicians of any specialty."

Some of the major areas to be addressed include:

* Environmental health hazards and counseling worried patients about their risks,
* Pediatric environmental health: children as a population at special risk, and
* Environmental factors affecting respiratory health.

"Our goal is to provide timely, useful information for physicians and medical students," Dr. Becker said. "Most of us in primary care every day see patients who feel they have been accidentally poisoned by some paint or spray or dust they've breathed. It's important that everybody -- especially medical students -- become familiar with the most common issues."

Tours of the new MU Medical Center will be offered from 4:30 to 5:30 p.m. Clinical faculty members and other CME participants are invited to participate in the Alumni Homecoming faculty/ student mixer at 8 p.m. Activities for alumni Sept. 25 include golfing and tennis, a luncheon, self-guided building tours, and a tailgate party in preparation for Marshall's 7 p.m. football game with Temple.

More information is available from the Office of Continuing Medical Education, 691-1770.

New laser system treating skin lesions, varicose veins

University physicians now offer a new non-invasive treatment for varicose veins, skin lesions, and unwanted hair using the VascuLight System, a pulsed laser and intense light system.

The selective photothermolysis system can penetrate to sufficient depths to reach deeper vessels and can be used at sufficiently high energy levels to selectively damage larger vessels without causing thermal damage to surrounding tissue.

It treats a wide variety of benign vascular and pigmented lesions, including rosacea, port wine stains, hemangiomas, sun spots, age spots, lentigines, hairy nevi and multicolored tattoos.

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West Virginia School of Osteopathic Medicine News

Sixty-two students earn D.O. degrees

Donald Newell, D.O. *(center)*, the keynote speaker at WVSOM's graduation ceremony, accepts an honorary degree from Dr. Olen Jones, president of WVSOM *(left)*, and James Stookey, D.O., dean of WVSOM.

The WVSOM celebrated its 22nd annual commencement on May 29 as 62 students earned Doctor of Osteopathy degrees.

"WVSOM is in the top 50 primary care medical schools in the country according to the U.S. News & World Report magazine," said WVSOM President Olen Jones, Ph.D. He also pointed out that the school ranked first in several categories, including the percentage of grads entering primary care fields.

"We are making a difference and it's something we can all be very proud of," Dr. Jones said. "However, many areas of our state still suffer from a lack of adequate medical care. Our school was created specifically to meet these shortages. This ranking from U.S. News is a wonderful affirmation that we doing our job and doing it well."

Don Newell, Jr., D.O., a primary care physician from Oak Hill was the keynote speaker for commencement, and he received an honorary doctor of science degree. Dr. Newell is chairman of the WVSOM Board of Advisors and the medical examiner for Fayette County.

Also receiving an honorary degree from WVSOM was Douglas Ward, Ph.D., a senior consultant with the American Osteopathic Association.

Brown promoted to professor of physiology

Brown

David Erwin Brown, Ph.D., of the WVSOM, was recently promoted to full professor.

Dr. Brown was promoted to professor of physiology, and he is the present director of the physiology courses and the renal system at WVSOM. He has been a member of the faculty since 1987.

Dr. Stookey awarded honorary degree

James R. Stookey, D.O., F.A.A.O., was awarded an honorary doctor of osteopathic education degree by the Kirksville College of Osteopathic Medicine (KCOM) on June 6 during the Class of 1999 commencement exercises.

Dr. Stookey, vice president for academic affairs and dean of the WVSOM, has honored for his contributions to the college as well as to the osteopathic profession.

Dr. Stookey is a 1959 graduate of KCOM and was a member of the KCOM faculty for 23 years. He has been an administrator at WVSOM since 1988.

Anatomy, osteopathy continuing education programs presented

Jim Nemitz, Ph.D., professor of anatomy, and William Lemley, D.O., associate professor of family practice, recently taught continuing education programs for several local professional groups — the Greenbrier Valley Physical Therapy Study Club, and the staff of The Greenbrier Spa & Salon.

According to Dr. Nemitz, he enjoys sharing his expertise and points out that enthusiasm for the program is spreading. "This is the third year that I've conducted a continuing education program for groups in the community who are interested in learning more about the human body and the way it works," said Dr. Nemitz.

The program for the physical therapists was designed to help them better understand some of the reasons their patients fall, and the program delivered to The Greenbrier Spa staff focused on anatomical reasons that people suffer back and neck pain.

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Celebrating 75 years of caring for West Virginians

The Alliance will celebrate its 75th annual convention when we convene at The Greenbrier in August. Since the Alliance was first created, we have endeavored to improve health conditions for all West Virginians, as well as provide a support system for the spouses of physicians in the state. Our members should take great pride in how well they have accomplished these two goals and how our organization continues to make a difference in the lives of so many individuals every day.

Since this is my last message as president of the Alliance, I would like to take this opportunity to thank the staff of the WVSMA for being such an invaluable resource to me and all the members of the Alliance. Their efficiency and kindness will always be appreciated. Christina Dixon, the executive secretary for the Alliance, has made sure that I have met my deadlines, and that is a minor miracle. I'm sure that this support will continue with our new president, Rose Romero, who will be installed on August 27 at The Greenbrier.

Looking ahead to next year, the Alliance will be a state-wide sponsor of the Walk for the Cure. Our major health emphasis this year has been on breast cancer awareness. Thousands of women have learned the importance of self exam and how to perform those exams. This is just one example of what we can do together.

This past year has been extremely rewarding for me personally. As the first male to do this job, I wasn't sure how I would be received. My travels throughout West Virginia have been an experience that I shall treasure. I have met many wonderful people and made many new friends. Thanks again for all you do for the Alliance. I'm looking forward to seeing everyone at The Greenbrier!

Jerry Crites
President, WVSMA Alliance

New Members

We are pleased to welcome the following new members to the WVSMA:

Physicians

Sandra M. Morar, MD
Wheeling, WV

Pamela Phillips, MD
Charleston, WV

John J. Anton, MD
Charleston, WV

Marsha L. Bailey, M.D.
Hurricane, WV

Nil Ranade, MD
Summersville, WV

Myron N. Senchyshak, MD
Weirton, WV

Donald G. Jansen, MD
Hedgesville, WV

Atul S. Shetty, MD
Weirton, WV

William DiFilippo, MD
Clarksburg, WV

Allan B. Kunkel, MD
Petersburg, WV

Jean-Michel F. Hyacinthe, MD
Beckley, WV

James H. Blume, DO
Forest Hill, KY

Sanjay S. Mardolkar, MD
Follansbee, WV

Michael A. Istfan, M.D.
Charleston, WV

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- Membership information;
- Legislative news;
- Details about upcoming meetings and events;
- Other important information you don't want to miss!
- Sign the guestbook and let us know you stopped by!

WWW.WVSMA.COM

WESPAC Members

We would like to thank the following individuals for their recent contributions to WESPAC:

Physicians

A Dollar A Day Club Members ($365 or more)

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Phillip R. Stevens

Central
Greenbrier Almond

Greenbrier Valley
Stephan Thilen

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Monongalia
Dorian Williams

Alliance Members

Sustainer Members - $50

Harrison
Joyce Rabanal

Attend the WESPAC Meeting at the WVSMA Annual Meeting!

Friday, Aug. 27
1:30 p.m.
Hayes Room
The Greenbrier

Obituaries

Harold David Almond, M.D.

Dr. Harold Almond, 84, of 30 W. Victoria St., Buckhannon, died on May 26 at this home.

Dr. Almond was born in Milburn, N.J., a son of the late Henry David and Catherine Hankins Almond. He received his M.D. degree from Northwestern University in Chicago in 1946 and interned at St. Luke's Hospital. He served as a captain in the Army Air Corps during World War II.

During his career in Buckhannon, Dr. Almond was active on the staff at St. Joseph's Hospital and organized the first emergency room at the hospital. He was a professor in the biology and chemistry departments at West Virginia Wesleyan College, where he also served as the college physician and hosted 99 international students.

Dr. Almond had been a member of the WVSMA since 1950, and he was a member of the Central West Virginia Medical Society, the AMA and the American Academy of Family Physicians. He was active in the development of the Appalachian Trail, as well as the Boy Scouts of America and the 4-H. In addition, Dr. Almond was the originator of the Sweetest Strawberry Contest.

Dr. Almond was preceded in death by his wife, Lois Ruth Flanagan Almond, and his two brothers, Richard Almond and Ralph Almond. He is survived by his four daughters, the Rev. K. Almond, Clarksburg, Annie Almond, Durham, N.C., Ruth Almond Wiewiora, Orlando, Fla., and Beth Almond Ford, Buckhannon; a son, Dr. Greenbrier Almond, Buckhannon; three sisters, Mildred Hacela, Newark, N.J., Dorothy Sutton, Westfield, N.J., and Grace Treible, Newton, N.J.; a daughter-in-law, Araceli Ganan Almond, Buckhannon; three sons-in-law, Thom Keely, Clarksburg; Richard Low, Durham, N.C., and Richard Wiewiora, Orlando, Fla.; two granddaughters, Maria Luisa Ganan Almond, Buckhannon, and Ginger Almond Low, Durham, N.C.; and five grandsons, Roncevert David Ganan Almond, Buckhannon, Taylor Flanagan Ford, Brandenton, Fla., Joseph Wiewiora and Christopher Wiewiora, both of Orlando, Fla., and Jesse Low, Durham, N.C.

Contributions may be made to the West Virginia Wesleyan College Flanagan-Almond Scholarship Fund, Appalachian Trail Conference Fund at Harpers Ferry.

Robert Thomas Bandi, M.D.

Dr. Robert T. Bandi, of Wheeling, who was a doctor to hundreds of children and families throughout the tri-state area, died April 28, 1999, in Ohio Valley Medical Center, Wheeling. He was 87.

Dr. Bandi was born June 25, 1912, in Wheeling, the son of the late William Nicholas Bandi and Sophia Findt Bandi. He earned A.B.
and B.S. degrees from West Virginia University and received his M.D. degree from Rush Medical College in Chicago. He was a member of Phi Delta Theta Fraternity, and Phi Chi Medical Fraternity.

During World War II, Dr. Bandi served in Europe as a captain in the Army Medical Corps. Following his military service, Dr. Bandi began his practice in pediatrics in Wheeling and served the community for 47 years. He served as chief of pediatrics at both Ohio Valley Hospital and the former North Wheeling Hospital during his career. He was also team physician for the former Linsly Military Institute from 1964-67, and was the team physician for the former Wheeling Ironmen professional football team.

Dr. Bandi had been a member of the WVSMA since 1941. He was a past president of the Ohio County Medical Society and was a member of the Southern Medical Society.

Dr. Bandi was a lifelong member of Christ United Methodist Church in Wheeling, where he was past chairman of the church building committee and a nine-year teacher of adult Sunday school classes. He served as president of the Short Circuit Club, Wheeling, was a member of Bates Lodge AF&AM, the Elks Lodge, and a member of the Good Zoo at Oglebay Park.

In addition to his parents, he was preceded in death by his son, Gary Morgan Bandi; a brother, Russell Bandi; two sisters, Ruth Wilson and Hilda Winters. Surviving are his wife of 53 years, Elizabeth "Betty" Morgan Bandi; a daughter, Mrs. Donald J. (Pamela Sue) Milton of Wheeling; two sons and daughters-in-law. Robert Bruce and Diane E. Bandi and Timothy Kirk and Jill L. Bandi, all of Wheeling; eight grandchildren, Kimberly Colvin Bandi of Charleston. Kelly Elizabeth Bandi Stewart of Charlotte, N.C., and Kitt Susanne Bandi of Wheeling, Donald J. Milton. Timothy Kirk Bandi II, Robert Samuel Milton, William Brandon Bandi and Patrick O'Neal Milton, all of Wheeling.

Memorial contributions may be made to Christ United Methodist Church, 1232 National Road, Wheeling, WV 26003.

Vernon E. Duckwall, M.D.

Dr. Vernon E. Duckwall, 91, of Elkins and formerly of Van Wert, Ohio, died May 14, in Van Wert County Hospital following an auto accident in Van Wert, Ohio.

Dr. Duckwall was born Feb. 1, 1908, in Scott, Ohio, a son of the late Francis C. Duckwall and Alice Brown Duckwall. He graduated from the University of Pennsylvania, Wharton School of Commerce and Finance in 1929. He served as a casualty and underwriter for the Travelers Insurance Co. and also as a publisher's representative for Conde Nast Publications of New York City.

Following graduation from the Columbia School of General Studies, Dr. Duckwall he attended the Columbia University of Medicine College of Physicians and Surgeons, where he received his M.D. degree in 1941. His internship and residency were completed at the New York Post Graduate Hospital, now known as University Hospital.

In 1943, Dr. Duckwall entered the U.S. Army Medical Corp and he was discharged as a major after 18 months in Europe during World War II. On Sept. 1, 1949, Dr. Duckwall started a practice in Elkins and joined the staff at the Golden Clinic and Memorial General Hospital. He later became associated with the Davis Memorial Hospital, retiring in 1980.

A fellow of the American College of Surgeons, Dr. Duckwall was also a diplomat of the American Board of General Surgeons and a member of the AMA. He had been a member of the WVSMA since 1950, serving as an associate editor of the *West Virginia Medical Journal* from 1973-1991 and on Council for many years. He was also a past president of the Tygart's Valley Medical Society and was a member of the Southeastern Surgical Congress.

A member and past president of the West Virginia Division of the American Cancer Society, Dr. Duckwall served as a medical delegate and national committeeman. In 1976, he received the American Cancer Society's Annual National Divisional Award for outstanding service and devotion to the society.

Dr. Duckwall was a member of Elkins Kiwanis and a past president and past lieutenant governor of West Virginia Kiwanis. He was a member and former vestryman of the Grace Episcopal Church in Elkins. He also belonged to the Elkins Elks Lodge, Isaac Van Wert American Legion, the Randolph Lodge No. 108 Free and Accepted Masons, Scottish Rite of Wheeling, Osiris Temple of Wheeling, and the Tygart Valley Shrine Club.

Dr. Duckwall was married twice. First, on June 1, 1934, in New Rochelle, N.Y., to Evelyn Smith, who preceded him in death on Nov. 14, 1973. Second, on October 12, 1974, in Elkins, he married Betty Jean Rosier Furhman, who survives in Elkins. Also surviving are a daughter, Mrs. Samuel (Patricia) Selwood, Penn Yan, N.Y.; a stepdaughter, Christine Smith, Oldfield; a granddaughter, Michele Shaar, Brunswick, Ohio; two great-grandchildren, Alexander and Mark Shaar, both of Brunswick, Ohio; and two step great-grandchildren, Joshua and Jennifer Smith, Oldfield. He was preceded in death by sister, Eloise Duckwall.

John William Trenton, M.D.

John William Trenton, 81 of Kingwood, died May 12, 1999, at home.

Dr. Trenton was born July 13, 1917, in Petersburg, son of the late Walter David and Edna Hamstead Trenton. He earned his A. B. degree in pre-medicine from WVU in 1938, where he was in Phi Beta Kappa, and then obtained his M.D. degree in 1942 from the University of Pennsylvania.

Dr. Trenton was in the U.S. Navy, with an internship at the Bethesda, Md., U.S. Naval Hospital. He also worked in the Naval Aviation Cadet Recruitment Station in Atlanta, was in Destroyer Escort Division 13, and worked in U.S. Naval hospitals in St. Albens, N.Y., Portsmouth, Va., Philadelphia, and Portsmouth, N.H. He was also stationed in Tsingtao, China, and on the U.S. Naval Hospital Ship Consolation in Korea.

In 1955, Dr. Trenton resigned as chief of surgery at the U.S. Naval Hospital in Portsmouth, then moved to Kingwood and helped staff the new Preston Memorial Hospital. He practiced in Kingwood until he retired in 1982.

A past president and governor of the West Virginia Chapter of the American College of Surgeons, Dr. Trenton was also a member of the American College of Surgeons and the American Board of Surgery. He was a clinical professor of surgery at WVU, retiring in 1987. In addition to being a member of the WVSMA, Dr. Trenton was a member of the AMA and a member of the Preston County Medical Society.

Dr. Trenton was also a member of City Council, Kingwood Rotary and the Preston County Club (where he was past president and on the board of directors). He was general chairman of the Preston County Buckwheat Festival, was an elder in the First Presbyterian Church, and was chairman of Kingwood Public Library.

Dr. Trenton is survived by a son and spouse, Walter David and Carolyn Trenton, of Somerset, Pa.; a daughter and spouse, Deborah and Arandy Livengood, of Kingwood; a brother, Arthur Francis Trenton, of Petersburg; and five grandchildren, Brooke Trenton and John David Trenton, both of Somerset, Pa., and Bryan Livengood, Matthew Livengood and Kelly Livengood, all of Kingwood.

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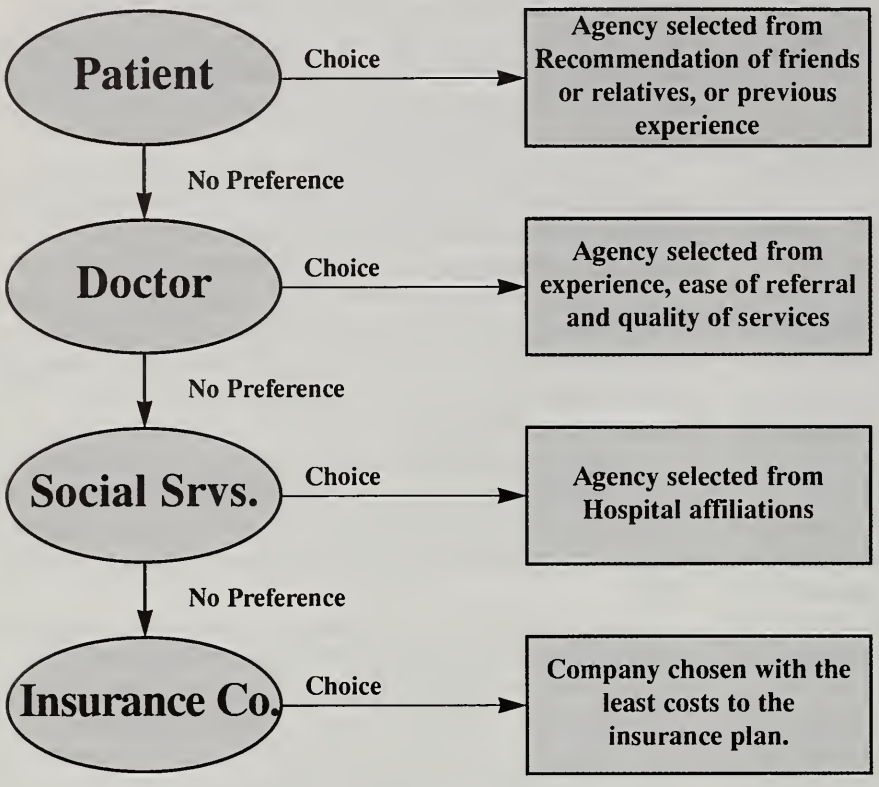

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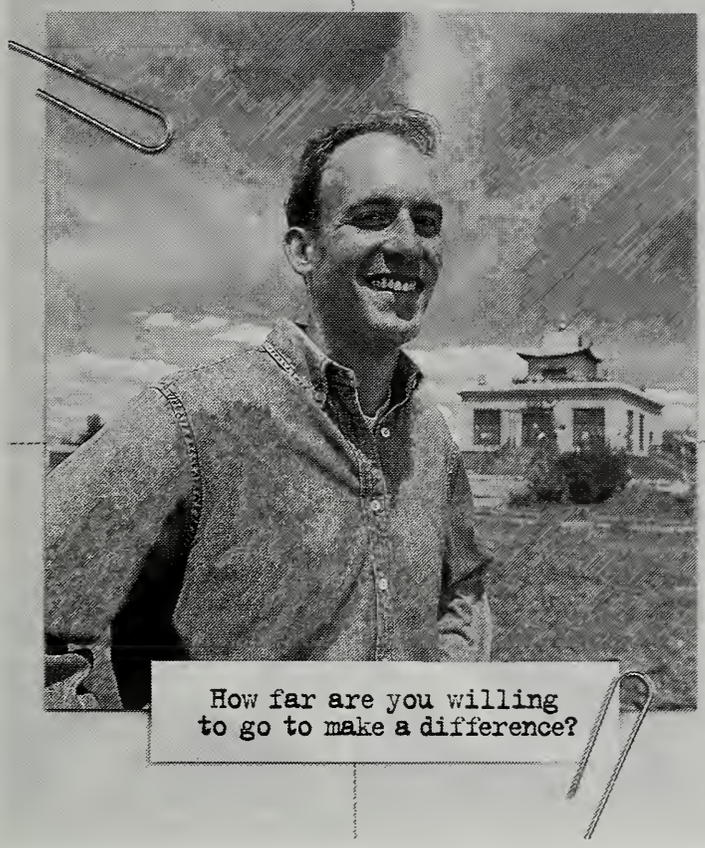

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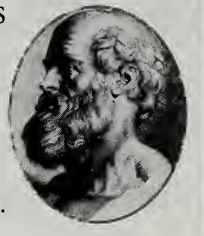

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14th Annual Trauma Conference
Friday, November 5, 1999
8 a.m. - 4 p.m.
Tamarack, Beckley, WV
James W. Kessel, MD
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13th Annual Research Day Conference
Thursday, November 11, 1999
5 p.m. - 7:30 p.m.
Robert C. Byrd Health Sciences
Center of West Virginia University/
Charleston Division, Auditorium
Joseph T. Skaggs, MD
Michael J. Lewis, MD
Program Chairmen

19th Cardiovascular Conference at Snowshoe
January 31-February 2, 2000
Mountain Lodge Conference Center
Snowshoe, WV
William H. Carter, MD, FACC
Program Chairman

Issues in Medical Ethics Basic Certificate Program
Friday, March 3, 2000
8 am. - 4:30 p.m.
Camcare Health Education and
Research Institute, Education and
Training Center
Mary Lou Lewis, MD
Robert T. Hall, PhD
Program Chairmen

On-Site Continuing Education Outreach Programs

Difference Between Schizophrenia and Bipolar Disease
Wednesday, November 3, 1999
12:30 p.m.
Montgomery General Hospital
Montgomery, WV
Martin Kommor, MD

Transition Back to Work After Lower Back Pain Injury
Friday, November 12, 1999
Noon
Logan General Hospital
Logan, WV
Marsha Bailey, MD

Community Acquired Pneumonia
Tuesday, November 16, 1999
6:30 p.m.
Roane General Hospital
Spencer, WV
Juan D'Brot, MD

Acute Abdominal Pain
Wednesday, November 17, 1999
6:00 p.m.
Man ARH
Man, WV
Stacey Copeland, MD

Guest Lectures/Tumor Conference

Diabetes and Erectile Dysfunction
Thursday, November 4, 1999
Noon
Family Practice Center
1201 Washington Street, #108
Charleston, WV
Steven R. Grubb, MD

Cervical Cancer: New Developments
Monday, November 8, 1999
Noon
Robert C. Byrd Health Sciences
Center of West Virginia University/
Charleston Division, Room 2000
Michael Schiano, MD

Amiodarone in Cardiac Arrest: Clinical and Operational Perspective
Wednesday, November 10, 1999
Noon
Robert C. Byrd Health Sciences
Center of West Virginia University/
Charleston Division, Auditorium
Edgar Gonzales, PharmD
Medical College of Virginia
Richmond, VA

Use of Atypical Anti-Psychotics in the Elderly
Thursday, November 11, 1999
9 a.m.
CAMC General Division
Rooms 101-102
John Kasckow, MD
University of Cincinnati College
of Medicine
Cincinati, OH

Management of Cancer of the Oropharynx
Monday, November 22, 1999
Noon
Robert C. Byrd Health Sciences
Center of West Virginia University/
Charleston Division, Room 2000
Austin Wallace, MD

Thyroid Cancer: New Developments
Monday, December 6, 1999
Noon
Robert C. Byrd Health Sciences
Center of West Virginia University/
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Steven Artz, MD

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Fall color at Plum Orchard Lake in Fayette County.

Photo courtesy of David Fattaleh, West Virginia Department of Commerce.

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Manuscript Guidelines

All articles for the *West Virginia Medical Journal* must be submitted on an IBM compatible disk. Microsoft Word 97 is preferred, but other languages are acceptable. If the manuscript contains tables, the main body of the manuscript and references should be saved as one item, i.e., *article*, and then each table should also be saved as a separate item, i.e., *Table 1, Table 2*.

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All scientific material is reviewed by the editor and three members of the Publication Committee. Other articles are usually only reviewed by the editor. All articles should be addressed to:

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If you have questions or need more information, phone Nancy L. Hill, managing editor at (304) 925-0342.

In Memoriam

Stephen D. Ward, M.D., R.I.P.

Newsman Tom Brokaw recently published a collection of vignettes about World War II veterans and their accomplishments in the succeeding 50 or more years. He tells the tales of men and women tempered by war who went on to shape and influence the growth of this country. He called these people *"The Greatest Generation."*

On Oct. 7, 1999, the WVSMA lost Stephen D. Ward, M.D., one of our outstanding members of The Greatest Generation. I suspect Dr. Ward probably viewed Tom Brokaw as a little too liberal in his news commentaries. Nevertheless, Dr. Ward's life certainly illustrates very well the point Brokaw was making in his book.

Dr. Ward was a native of Pittsburgh, who graduated from Mount Lebanon High School where he was an All State center on the football team. He attended LaSalle Military School in Long Island before joining the U.S. Army in 1943.

Dr. Ward entered the European Theater of Operations as a member of the 17th Airborne Division. During the Battle of the Bulge, he sustained a head wound from an exploding tank round. After brief treatment, he was returned to the front and later awarded the Purple Heart for this action. Like many of the men and women of his generation, Dr. Ward talked very little about his wartime experiences.

Following his military service, Dr. Ward enrolled at the University of Pittsburgh, where he received a B.A. degree in 1950 and his medical degree in 1954. While at the university, he resumed his football career, earning three varsity letters until he sustained a knee injury in a game against Notre Dame which halted his playing career.

Stephen D. Ward, M.D.
Feb. 9, 1925 - Oct. 7, 1999

After medical school, Dr. Ward remained in Pittsburgh for his internship at Mercy Hospital and his residency at Western Psychiatric Institute. From 1958-61, he practiced psychiatry in Mount Lebanon, Pa., and worked at Mayview State Hospital outside of Pittsburgh.

In 1961, Dr. Ward moved his family to Wheeling so he could join the staff at Wheeling Clinic, where he practiced psychiatry until his retirement in 1995. During his years at Wheeling Clinic, he served as chairman and was also very active on the staff at Ohio Valley Medical Center where he served as president of the medical staff in 1983, and was chairman of the Dept. of Neurosciences and medical director of the Psychiatric Dept.

Dr. Ward became a member of the WVSMA in 1962 and soon became very active on the Legislative Committee, Council and the WESPAC board of directors. In 1971, he was named an associate editor of the *West Virginia Medical Journal*, and in 1976 he rose to his cherished post as editor. It is interesting to note that the only other editor with a longer tenure than Dr. Ward's was Dr. Walter Vest, who was editor from 1937-1962.

Under Dr. Ward's watch, the *Journal* has seen a number of transitions, including full-color covers depicting West Virginia scenes and a change from monthly to bimonthly publication. Even though there have been some changes in content and layout throughout the years, Dr. Ward always provided readers with quality articles and thought-provoking editorials. He was an astute observer of the American political scene, especially as it related to medicine. I have for many years thought of him as medicines' Andy Rooney, he sometimes made us mad, but he always made us think!

In addition to his involvement with the *Journal* and the other WVSMA committees I have mentioned, Dr. Ward went on to serve as president of the WVSMA from 1979-80, and as an alternate delegate and as a delegate to the AMA for many years.

At the national level, Dr. Ward's presence at the AMA will also be greatly missed. He served on the AMA's Council on Legislation for 12 years and was the AMA's representative on the Legislative Council of the American Dental Association. Since 1995, Dr. Ward had been on the editorial advisory board for the AMA's publication *Senior Physician News*.

During his career, Dr. Ward also served as president of both the Ohio County Medical Society and the West Virginia District Branch of the American Psychiatric Association. He was a fellow of the American Psychiatric Association, and was a clinical associate professor in the Dept. of Behavioral Medicine and Psychiatry at WVU.

Although most of us knew Dr. Ward best for his contributions to medicine, all of that was secondary to his love and devotion for his family. We thank them for sharing his talents with us and extend them our deepest sympathies.

F. Thomas Sporck, M.D.

Although I feel woefully inadequate to write about a man with such a powerful command of the English language, I feel compelled to write this tribute about Dr. Stephen D. Ward because my perspective may be different from many other WVSMA members.

From the time I first met him as a teenager, I admired Dr. Ward in many capacities including family man, physician, partner and leader of various physician organizations and committees. Particularly in his leadership positions, he was determined and non-compromising. He liked to "agitate" (his word) and would be disappointed by tepid response from others. There were those who objected to his style, perhaps seeing him as combative and domineering.

I did not always agree with him. I respected him because his positions were based on what he saw was best for the organization, not for himself. He was willing to take unpopular stands knowing that he would get knocked down. He was back up the next day with a remarkably positive attitude.

As demonstrated in his years of meticulously written and hard-hitting editorials for the *Journal*, Dr. Ward was dedicated to preserving the physician/patient autonomy while condemning those out to undermine it. He was intolerant of physicians or those in organized medicine who would give any ground in this area.

Along with his profession, Dr. Ward had several sources of pride. His greatest sources of pride were his wife, his children, and his grandchildren. Those of us who know them can undertand why.

At the end of his life when he was dying from a cancer so cruel that a brain metastasis severely limited his ability to express himself, he had no self pity. With his family at his side, he kept the same remarkably positive outlook with nothing but appreciation for those involved in his care.

I will always be grateful for Dr. Ward's support and encouragement of my decisions to go into medicine, to return to Wheeling to practice, and of course, to become actively involved in organized medicine. I will miss his wit, his wisdom and his counsel.

The editorial board of the *Journal* has a significant challenge to maintain the standard of excellence he established as editor. All of us should be as proud of being called a physician as he was and be as determined to protect the practice of medicine as he expected us to do.

John D. Holloway, M.D., F.A.C.P.

Editorial

House passes significant patients' rights legislation

The United States House of Representatives passed the Norwood Dingell Bill (HR 2723), bipartisan patients' rights legislation, on October 7. This important legislation features six principles of reform advocated by the patient access coalition, which is composed of the AMA and 129 other members from various medical and patient consumer groups.

The six points included are:

1. An out-of-network point of service option at the time of enrollment;
2. Timely access to specialty care;
3. A fair and expedited independent appeals process;
4. A consumer information check list;
5. A ban on financial incentives that result in the withholding or denial of care, or denial of a referral; and
6. A ban on gag clauses.

The WVSMA strongly supports the Norwood Dingell Bill which would cover all 161,000,000 privately-insured Americans. It gives physicians the authority to determine what is medically necessary for their patients and what must be provided by the plan.

In addition, this bill provides patients with the right to sue their managed care plans in state courts. At this writing, the full ramifications of this segment of the legislation are not clear. We should reserve support of this portion of the legislation until we have further clarification.

The House leadership attached HR 2990, a tax relief bill, to Norwood Dingell at its passage. HR 2990 would grant tax relief for certain health insurance expenses and medical savings accounts. President Clinton has vowed to veto the Norwood Dingell legislation unless the components associated with this tax relief bill are removed.

On July 15, the United States Senate passed their Patient Protection Bill (S 1344). This legislation is not nearly as strong for patients' rights as the House legislation and it covers only about 40 million Americans, a fraction of those covered by Norwood Dingell.

The next hurdle for this patient protection legislation will be the House/Senate Conference Committee, where the final draft of this bill will be developed. As we go to press, only Senate members of the Conference Committee have been named, and luckily, West Virginia's Senator Jay Rockefeller is a member!

The other members are:

Jim M. Jeffords (R-VT);
Judd Gregg (R-NH);
Bill Frist (R-TN);
Tim Hutchinson (R-AR);
Michael B. Enzi (R-WY);
Don Nickles (R-OK);
Phil Gramm (R-TX);
Edward M. Kennedy (D-MA);
Christopher J. Dodd (D-CT);
Tom Harkin (D-IA); and
Barbara A. Mikulski (D-MD).

It is extremely important that WVSMA members contact Senator Rockefeller to stress how important this legislation is for consumers throughout the nation. If they have a relationship with any other of the conferees, they should contact them as well.

Speculation is that even if the House members of the Conference Committee are appointed in the near future, an agreement between the House and Senate is not expected until sometime in the year 2000. In addition, the final bill that comes out will depend very much on the make-up of the committee.

Although for the first time in six years a meaningful Patient Protection Bill has been passed by the U.S. House of Representatives, it is questionable what form this legislation will be in once it comes out of the Conference Committee. Furthermore, it is also highly debatable whether or not the President will even sign the bill once the Conference Committee is finished with it.

Patient protection is a critical issue. Once the House members of the Conference Committee are selected, we will quickly notify WVSMA members of their names so these individuals can be contacted.

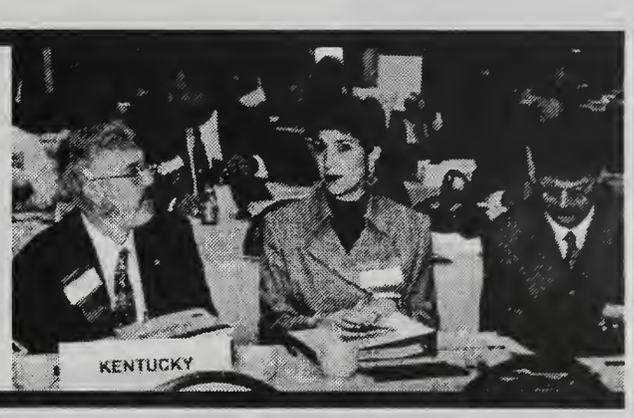
F. Thomas Sporck, M.D.

American Medical Association
Organized Medical Staff Section (AMA-OMSS)

invites your medical staff to be represented at the

1999 Interim Assembly Meeting, December 2-6, in San Diego

Vision
Voice
Victory



If physicians want to be effective agents for change in improving today's health care, they need ***a vision, a voice, and a victory.***

The vision comes from grassroots physicians...representives of hospital or other health care organization medical staffs...that come together in a national forum to share ideas, concerns, and interests.

The voice is the AMA-OMSS. It resonates within the AMA and is projected to Congress, private and public sector leaders, and the public through the implementation of policy and other advocacy initiatives.

The victory is the fruit of your effort to make a difference.

Be part of the process. Send a representative* from your medical staff to the **1999 Interim AMA-OMSS Assembly Meeting, December 2-6, in San Diego**. *There is no fee to attend.*

OMSS representatives can:

- Submit resolutions prior to the Assembly meeting.
- Testify at Reference Committee hearings and vote in the Assembly.
- Participate in special issue forums.
- Network at state and regional caucuses.
- Attend education programs. (*Topics include: managed care contracts, new CPT codes and software, preventing and managing adverse outcomes, improving physician image through community involvement, protecting your practice from embezzlement, conflict of interest policies, technology and medical staff reengineering, ways to be an effective agent for change, reestablishing collegiality in the medical profession, and federal and state legislative affairs.*)

For more information on how to register, call **800 262-3211** and **ask for the Department of Organized Medical Staff Services** or e-mail us at **omss@ama-assn.org**.

* Must be an AMA member

American Medical Association

Physicians dedicated to the health of America

Special Section

Highlights of the WVSMA Annual Meeting

The Greenbrier
August 25-28, 1999

Inaugural Address

Health care in the 90s, the Gathering Storm

Dr. Phillip R. Stevens, the WVSMA's president for 1999-2000, delivered his inaugural address during the Second Session of the House of Delegates on Saturday, August 28.

Thank you. Thank you all for allowing me this great honor. I would also like to thank you for being here today to share this event with me, family, friends, fellow physicians and their families, as well as visiting dignitaries. I am deeply honored and very humbled.

Before I get started, I want to congratulate Evan Jenkins and the staff of the WVSMA on a great meeting and a job well done! Would Evan and the staff please stand! Terrific job!

This past year has been one of tremendous change for the WVSMA and a very busy year, although, I imagine David will tell me "you ain't seen nothing yet!" There isn't anyone in this room happier than he is right now. Look at that smile! Congratulations also to David for a tremendous job this year!

As I look around the room today, I see so many family and friends, people who have been so important to me as I journey through this remarkable experience we call life! Without the help and support of all my family and friends, I would not be where I am today and for all of you I am truly grateful and truly blessed.

My mother and father instilled a strong work ethic in me and my father, Dr. Frank Stevens, led the way in service organizations serving in the past as a PTA president of Johnson Elementary School in Bridgeport, W.Va., president of the Harrison County Board of Education, president of the West Virginia State Dental Association and on the Board of Directors of the ADA. We are the first father/son team to serve as president of the WV Dental Association and the West Virginia State Medical Association.

I especially want to recognize the most important person in my life, my lovely wife, Susan. She has been with me from the beginning on my medical career, has stood with me through thick and thin, has supported me completely in all my endeavors, but has also not been the least bit bashful about telling me when I'm wrong, which is important. And she has also undertaken the lion's share of the work in raising our four wonderful children. Susan, I love you and don't know what I would have done without you. Thank you from the bottom of my heart. And here are our kids! Nathan, Laura, Sarah and Molly.

As I mentioned earlier, the WVSMA has gone through a lot of change this year. I believe the organization has to become much more effective politically. To do this, we must build effective working relationships with many other groups. We must continue to build on our recent detente with the hospital association. We must build coalitions with the Chamber of Commerce, the Nurses Association and all other allied health groups. In this way, we can present a united front to the Legislature on the issues

we do agree on. If we can build a big enough army, then we will start winning some of the battles.

But, politics in general and WV politics in particular can get very complicated and appearances can be deceiving. It reminds me of the story I heard recently of two old codgers sitting in the park discussing the upcoming Republican National Convention. One old man said, "I'm going to vote for Bush. I like what he did in the Persian Gulf War. To which the other old man says, "Well, I'm going to vote for Dole, but I wish he would quit dressing up like a woman!"

This year we are going to work hard to get it **right** and improve our performance in the legislative arena. To do this though, we are going to need everyone's help.

Today, I'm going to explain to you why every physician in the state of West Virginia should be a member of the WVSMA. **No** make that **needs** to be a member of the WVSMA. WVSMA in general and our AMA in particular were founded for three things:

1) ethics;
2) education and
3) to protect the physician - patient relationship.

All are important, but the one I am most worried about is the physician-patient relationship. **Every** patient seeing **any** physician anywhere in this great country should be able to have utmost faith in the physician-patient relationship. That physician should be working for you, the patient. **The physician-patient relationship is a time-honored bond and in reality is a sacred trust, given to no other profession but ours. And it is that very sacred trust that is under attack.**

Patients needs to know that their physician will do all in their power to determine what illness they have. And then that physician needs to be able to tell that patient what their options are for treating that illness. And I mean **all** options, not just some list that the managed care company says is available. And then the patient should be able to decide what treatment option is best for them, **not** the government, and **not** the managed care company. It is absurd that a physician who spent $^1/_3$ of their life in education needs to get approval for a necessary treatment or procedure from a high-school dropout insurance clerk looking at a computer screen at the other end of an 800 number.

Earlier this year, I was in Colonial Williamsburg chaperoning my daughter, Sarah's fifth grade class. We were on a three-day field trip and spent an entire day at Williamsburg. Now, I don't know how many of you have ever been to Williamsburg, but a momentous day in history is selected and then events that happened in Williamsburg are re-enacted throughout the day. When we were there, the day was April 29, 1775. British marines had just seized the colony's supply of gunpowder from the arsenal. Also on that day, word reached Williamsburg that the British had attacked the minutemen at Lexington and Concord. The theme for this day at Williamburg was *"The Gathering Storm."* It dawned on me as I was walking thru Williamsburg on that beautiful spring day chasing fifth graders, that *"The Gathering Storm"* sums up health care in the 90s. The government with their allies, the insurance industry, has launched an unprecedented attack on the house of medicine just as the British launched an unprecedented attack on the colonists.

Now, I'm not suggesting that Redcoats are going to fire on us, but there are analogies. For the colonists, the final straw was armed assault by Redcoats. For us, it very well may be fraud and abuse audits looking at E & M coding. For those of you in the audience who are not physicians, E & M stands for evaluation and management. It is a complex coding system that the government says must be used to document what was done in the office for **every patient visit.** Now as I said, the system is quite complex — like your income tax form — and every single mistake can be punished by a **$5,000-$10,000 fine and a year in jail.** If there is felt to be fraud, unfortunately the government gets to decide what's fraud. Now there are supposedly some protections and due process, but the bottom line is **a huge fine and years in jail!** And if you challenge the accusation and it goes to trial and you lose — **the fines are tripled!**

The Justice Department with the FBI is spearheading the attack. Medical schools at major universities were targeted first, through what are called PATH audits — that's P.A.T.H., Physicians at Teaching Hospitals.

The fraud and abuse division of the Justice Department swoops into a university unannounced and demands to see the medical charts of all the Medicare patients seen at that hospital in a given year. And by law, the hospital must open the confidential charts of our patients to these government investigators. A year's worth of Medicare visits represents an unbelievable number of coding opportunities at most universities and guess what? They find a lot of coding mistakes! Not mistakes that affect patient care! It has nothing at all to do with patient care! Mistakes in how well you wrote down all that you did according to this complex coding system.

So these government investigators multiply all these coding errors by $10,000 and come up with an astronomical amount of money that they say the university owes the government. They threaten a trial and three times that amount if you lose. None of the accused universities has dared to go to trial yet. The University of Pennsylvania Medical Center settled for $30 million, University of Texas Health Service Center settled for $17.2 million, Georgetown University Medical Center, $5.3 million and the list goes on. **The University of Chicago has been hit with a $100,000,000 liability threat! One hundred million dollars. This is legal extortion and it is outrageous that our government is doing this.**

Unfortunately, I fear the worst is yet to come. The Justice Department is now beginning to move into phase two of the assault. Now, private practitioners are going to be audited and they have nowhere near the financial reserves of the major universities. **There is no doubt in my mind that honest, hard-working private practitioners are going to be ruined by this insane witch-hunt if something is not done.**

But what is to be done?

The situation with private insurance is no better. Managed care companies continue to lower what they will pay for our services and tell us to take it or leave it. And they do this when their profits are at record highs!

The race to the bottom that is going on now was unbelievable and unthinkable just 10 years ago. They have also taken aim at the sacred physician-patient relationship, telling us what care our patients need and don't need. Not that test, not that drug, etc. And then they have the audacity to send a letter to our patient, implying that we were wrong! This test, that procedure is not medically indicated. **How in the world would they know! How does the insurance industry dare to tell me what is best for my patient, having never laid eyes on them?** Yet, they do this every day many times over and the poor patient gets totally left out of the loop. They never ask the patient what they want.

They call this managed care. **Well, it's not managed care, it's managed finances and I have noted that they manage to keep most of the finances for themselves! We must put the patient first NOT the shareholder.**

But what is to be done?

There is much confusion and many opinions as to what course of action to take. The colonists faced a similar situation! What to do against the overwhelmingly powerful British Empire? How could the tiny American colonies take on the vast might and abundant resources of the mighty British Empire? Many were clamoring for peace, fearing any conflict with that all-powerful empire.

Sarah's class stood inside the colonial capital and recited in unison the stirring words of Patrick Henry. Sarah, it was a performance I will never forget. Patrick Henry's words thundered right out of the past. Listen carefully to his words!

"Besides, sir, we shall not fight our battles alone. There is a just God who presides over the destinies of nations, and who will raise up friends to fight our battles for us. The battle, sir, is not to be strong alone, it is to the vigilant, the active, the brave! Gentlemen may cry peace, peace — but there is no peace. The war has actually begun! The next gale that sweeps from the north will bring to our ears the clash of resounding arms! Our brethren are already in the field! Why stand we here idle? What is it that gentlemen wish? What would they have? Is life so dear or peace so sweet as to be purchased at the price of chains and slavery? Forbid it! All Mighty God! I know not what course others may take, but as for me, give me liberty or give me death!!

Powerful, powerful words. One can still feel the outrage and one can still feel that resolve. And as the echoes of Sarah's class died out, the exhiliration I initially felt melted into sadness and to be honest embarrassment for the house of medicine. **Where is our outrage? Where is our resolve? Will we stand idly by while government and insurance forces ride roughshod over our rights and more importantly the rights of our patients?**

Like the colonists, we too have friends who will rise up and fight our battles with us! Our patients! They, like us, are very concerned by the path we are on. Past AMA President Nancy Dickey sums this point up quite nicely. She says that our patients look at us and say you were the brightest ones in class, you were the brains. Why aren't you doing something to fix this?

Why indeed? Are we so fearful of conflict with the mighty insurance industry and government forces that we want peace at any cost? "Is peace so sweet as to be purchased at the price of chains and slavery?" Will we allow ourselves to be paid nothing, to be told how to take care of our patients, and to be threatened with jail by this unsavory alliance? In order to have peace? Forbid it! All Mighty God! Besides, there is no peace! **The war has actually begun! It is time to draw our swords and enter the battle! Failure to do so places our patients at enormous risk. Therefore, failure is not an option.**

To be fair, the forces we are up against are quite formidable indeed. But we must remember Patrick Henry's words, the battle is not to the strong alone. It is to the viligant, the brave and above all the active. **We must unite, all of us, every physician in the state and work to protect the physician-patient relationship because if we don't, we won't have a health care system worth a plug nickel.**

So, I am asking all physicians, from all specialties and from all walks of life to join me in a common goal, protecting the physician-patient relationship! I offer you a simple pledge! I pledge, as well as Evan Jenkins, the WVSMA's new executive director, and the rest of the physician leaders at the WVSMA, to be vigilant, to be brave and above all to be active. **If all of you will join us, there is no doubt that just like the colonists, we will win this war!**

Thank you and God Bless!!

Dr. Phillip Stevens celebrated his inauguration with his wife, Susan, and their children, Laura, Molly, Sarah and Nathan.

Follow the Yellow Brick Road

Dr. David W. Avery reflects on his year as president of the WVSMA during his address at the Second Session of the House of Delegates on Saturday, August 28.

It's hard to believe a year has gone by since I first addressed my colleagues, family and friends here at The Greenbrier. The message then is still appropriate for today — If we put our patients first, we can't go wrong. It's just good medicine.

The year 1999 certainly has been one of change. Despite the change in leadership at the WVSMA office, I believe we have weathered the storm very well. We have accomplished many things this year while creating a pathway for the future.

The Executive Committee completed one of the most challenging tasks it has had in many years. We were asked to select a new executive director. Someone in which we needed to have complete faith, and someone who we believed would not only handle the day-to-day management of our organization, but would help us write and implement our program of work for the future. It was without a doubt, one of the most thought-out decisions of our lives. I believe we chose the person who will do the best job for West Virginia physicians.

Nancie Albright did a great job as the Association's acting executive director and is responsible for many positive changes within the organization this year.

During the 1999 Legislative Session, the WVSMA had a proactive presence at the Capitol. Many people, including myself, never realized what lobbyists do on a daily basis. I have a new found respect for them. Both Steve Haid and Nancy Tonkin did a great job as our contract lobbyists. We were allowed access to places we were once denied and the WVSMA staff and membership were kept up-to-date every week about the latest happenings at the Legislature. Our new alliances with the West Virginia Hospital Association, the Nurses Association and others finally came to fruition. We still don't completely agree with them, but at least we are talking.

Several bills important to physicians and the medical community passed during this year's session. The Medical Practice Act, regulating telemedicine and strengthening due process all can be considered huge successes. The Volunteer Medical Licensure Bill — giving retired physicians a chance to work at free clinics, also passed, as did the Automatic External Defibrillator Bill. But, all of these bills took more effort than you would believe. Late evening lobbying by all of us, as well as other health organizations helped win many battles.

Yes, we won many battles . . . but we still have to win the war. Unfortunately, the provider tax still exists. This grossly unfair tax collected more than $130 million last year, and it won't go away without some form of replacement revenue.

I greatly enjoyed attending the component society meetings, but the message is still the same. Our apathy is killing us. We need to speak out and be heard.

The collective bargaining issue proposed and passed at the AMA meeting is a crucial one. Let me correct one statement from the Charleston Daily Mail. I stated to the reporter that I am not able to join a union, however, it was reported that I wouldn't join if I had the opportunity. Unfortunately, I am not currently able to join a union without some change in current legislation at the federal level, as is probably the case with most of us. We need to at least level the playing field with the managed care organizations.

As our membership survey shows, government affairs is a very important part of our Association. With Evan as our executive director, and an excellent staff, the WVSMA is laying the bricks for us to follow. We may make some wrong turns, but we are progressing.

Tort reform, the provider tax, managed care issues all lie ahead. We must be the professionals I talked about last year. We cannot simply have a job and work nine to five.

Finally, as my talk comes to a close, I would like to say that it has truly been an honor to have served as your president this past year. I need to thank all of the staff at the WVSMA office. They made it easy. One

person I specifically need to thank is Shirleen — who always told me where to go and when to do it.

I need to thank Steve Sebert for all of his advice. He has served as my surrogate brother and I have been his food taster. Also, Gene Cordell who has always listened to me with an opening line of "What did you do now?" My friends at home Bill and Ann Greer for their support and for listening to me complain.

I need to thank my nurses, Pam Hedges, Deloris Winder and Laurie Smith who have been with me for years (Pam for 17 years). They long ago became good friends and not simply employees. They managed to re-schedule more patients that I care to know. Along with that, we survived a change in my practice. We saw patients on Friday at the old office and a full day of patients at our new office on Monday. That wouldn't have happened without them.

My son, Seth, who when I talked to him on the phone while I was away at meetings, wanted to know, "Just exactly where are you?"

And finally I need to thank my wife, Elaine, who wanted a picture of me so she could remember what I looked like.

I leave the presidency in good hands. I am confident Phil Stevens will do a great job and help seach for the hypothetical "OZ" — as long as we follow our yellow brick road.

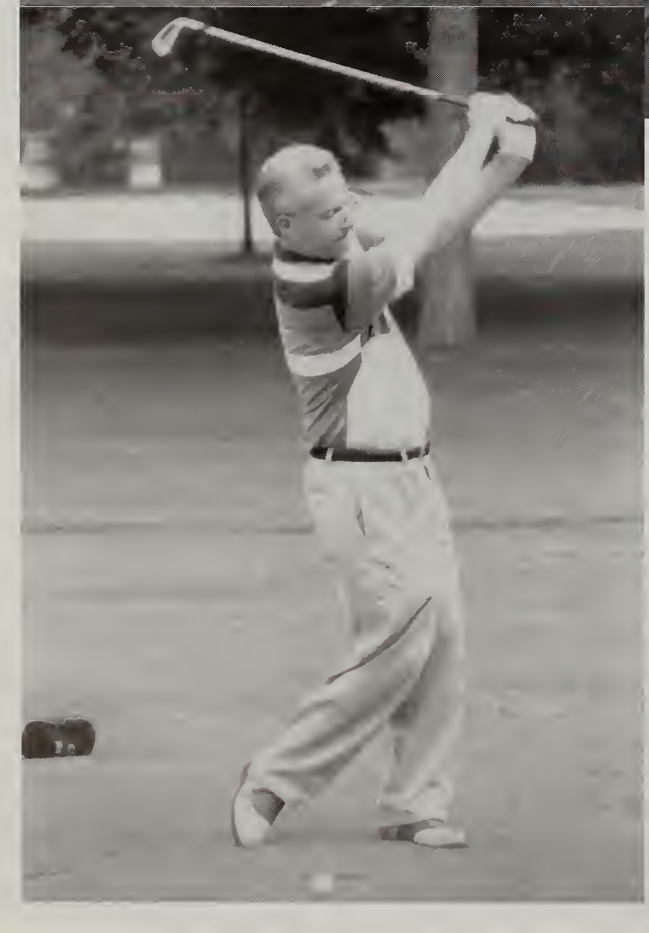
David W. Avery, M.D.
WVSMA President 1998-99

Following their addresses, Dr. Avery and Dr. Stevens are congratulated by Dr. John Holloway, president-elect of the WVSMA.

Dr. Avery and his wife, Elaine, visit with AMA President Dr. Thomas Reardon and Dr. James Helsley at the reception sponsored by the WVU and Marshall University Schools of Medicine.

WVSMA's 132nd Annual Meeting

(Top left) AMA President Dr. Thomas Reardon emphasizes a point during his address on *"The Changing Faces of American Medicine." (Top right)* WESPAC Chairman Dr. Doug McKinney proudly poses with Tracy Sinnott, regional director for AMPAC, after she presented WESPAC with a plaque for having the greatest percentage increase in revenue for a Tier 3 state. *(Center right)* Dr. Robert D'Alessandri, vice president for health sciences and dean of the WVU School of Medicine, and Evan Jenkins, WVSMA executive director, sport their *"Vote Holloway"* hats at the Friday evening entertainment. Dr. John Holloway *(center)* ran unopposed for president-elect of the WVSMA. *(Bottom left)* Dr. Henry Taylor, commissioner of the WV Bureau for Public Health, presented many interesting insights during his lecture on *"What Goes Around Comes Around: Public Health 1900-2000."*



(Top left) Dr. William Noble of Wheeling presented a lecture entitled *"Cardiac News"* during the Second General Scientific Session. *(Top right)* Linda Holmes of the Marshall University School of Medicine was such as outstanding tennis player that she played in the men's division and won top honors with Vijay Paul of Astra Zeneca. *(Center right)* Dr. James Helsley was the lucky winner of the deluxe cooler and specialty items from MetLife Financial Services which were presented to him by Steve Hyer of MetLife. *(Bottom)* Dr. Jeffrey Stead, chairman of the golf tournment, lines up a drive during the tournament. *(Center left)* Action was fast paced in the volleyball tournament.

(Top left) Craig Curry, supervisor of the Fraud Investigation Unit at Nationwide was the guest speaker for the Lunch & Learn program on *"Medicare Fraud in Cyberspace." (Top right)* Dr. Carlos Lucero of Beckley stands at the microphone to ask AMA President Dr. Thomas Reardon a question after his address. *(Bottom right)* Dr. Elizabeth Spangler, treasurer of the WVSMA, poses a question to Dr. Henry Taylor, commissioner of the WV Bureau for Public Health, after his lecture entitled *"What Goes Around Comes Around: Public Health 1900-2000." (Bottom left)* Guests at the reception hosted by Medical Assurance of WV and Acordia of WV, included Dr. Robert Marshall and his wife, Dr. Mabel Stevenson, president of the WVMI Board of Trustees; John Wiesendanger, vice president and CEO of WVMI; and Dr. Bill Atkinson and his wife, Carolyn. *(Center)* Dr. Ronald Cordell directs a question about Medicare to Craig Curry of Nationwide Medicare during the Lunch & Learn on *"Medicare Fraud in Cyberspace."*

(Top left) Rose Romero of Beckley, the new president of the WVSMA Alliance, presented an address during the Second Session of the House of Delegates. *(Top right)* Among the couples showing some fancy footwork on the dance floor during the Friday evening entertainment were Dr. Michael Fortunato and his wife, Kathy, and Dr. Phillip Stevens, the WVSMA's new president, and his wife, Susan. Acordia of West Virginia hosted this event which featured Waylon Thibodeaux, *"Louisana's Rockin' Fiddler,"* and his band. *(Bottom right)* Dr. James Comerci and his daughter, Michele, had fun dancing to the cajun beat of Waylon Thibodeaux and his band. *(Center)* Dr. David Avery, WVSMA's president for the past year, and his wife, Elaine, share a laugh while dancing. *(Bottom left)* Kelli Morgan, president of the Cabell County Medical Alliance, had a blast when she played the spoons with the band.

(Top left) Good buddies Dr. Joe Selby and Dr. Dorian Williams of the Monongalia County Medical Society delegation share a laugh before the start of the Second Session of the House of Delegates. *(Top right)* WVSMA Alliance member Jeanny Kalaycioglu, who is president of the Southern Medical Association Alliance, enjoyed visiting with Susan Paddack, president of the AMA Alliance, at the reception sponsored by the WVU and Marshall University Schools of Medicine. *(Bottom right)* Dr. Terry Elliott was the lucky winner of one of the gift baskets which were given as door prizes. Pictured in the background are WVSMA staff members Donna Webb and Christina Dixon, who presented the door prizes. *(Bottom left)* Dr. Thomas Chang and his wife, Wha Ja, visit with Dr. Alva Deardorff in the Exhibit Hall. *(Center)* Dr. Joe Reed talks with Joe Antonini and Shannon Lehman of the Robert C. Byrd Health Sciences Center of WVU at their exhibit booth.

(Top left) Broadway star Mark McVey entertained at the reception honoring his close friend Dr. Phillip Stevens, the new president of the WVSMA, and the other newly installed officers of the WVSMA and WVSMAA. *(Top right)* Dr. Ron Stollings congratulates Dr. Phillip Stevens as his arrives at the reception after his inaugural address. *(Center right)* Dr. David Avery presents Shirleen Lipscomb, the WVSMA's executive secretary, with a bouquet of flowers in appreciation for all her work to make the WVSMA's Annual Meeting such a success and for all her assistance during this past year. *(Bottom right)* Dr. Sarjit Singh, president of the WV Board of Medicine, talks with WVSMA President Dr. Phillip Stevens and WVSMA President-Elect Dr. Ahmed Faheem. *(Bottom left)* AMA President Dr. Thomas Reardon discusses issues with WVSMA Executive Director Evan Jenkins. *(Center left)* Dr. Sarjit Singh, president of the WV Board of Medicine, made a special presentation during the Second Session of the House of Delegates.

Resolution 1 *(Sub. Resolution Not Adopted)*

WHEREAS, the Public Employees Insurance Agency (PEIA) has chronically failed to provide a financially solvent program for public employee health insurance needs, and

WHEREAS, agents representing the various state employees groups have continuously succeeded in convincing the Legislature and the PEIA to provide insurance benefit packages well beyond the limits of program funding, and at inappropriately low cost to the employee, and

WHEREAS, the PEIA has thwarted its own cost-saving efforts at providing a managed care option, by making the premium cost to the employee for that option virtually identical to that of the indemnity plan, and by forcing the managed care plans to contribute an unfair portion of the total premium, and

WHEREAS, the PEIA has failed totally to bring down its pharmacy costs under control,

WHEREAS, the PEIA has seen fit to attempt to balance its poor administration of the health care needs of public employees by persistently lowering physician reimbursements to levels well below comparable rates paid by insurance programs for employees in the private sector, therefore, be it

RESOLVED, that the WVSMA support efforts to have PEIA further define benefits packages for its employees which are commensurate with the funding of that agency, and be it

RESOLVED, that the benefits packages thus defined advance the principle of making the beneficiary become an active participant in managing the costs of his/her health care, correlating premium contributions and out-of-pocket costs to the level and cost of care received, and be it

RESOLVED, that physician reimbursement by the PEIA for the care of state employees be maintained at levels commensurate with insurance plans providing health care benefits to employees in the private sector, and be it

RESOLVED, that the WVSMA work for the passage of legislation which will resolve in a comprehensive way the historically inadequate funding of PEIA.

Resolution 2 *(Disapproved - not necessary)*

WHEREAS, numerous people from WVSMA have complained about The Greenbrier charges, therefore, be it

RESOLVED, that the WVSMA investigates and pursues a policy of having the Annual Meeting held in a rotating manner in different locations throughout the state exculsive of The Greenbrier.

Resolution 3 *(Sub. Resolution 3 Adopted)*

WHEREAS, the WVSMA was established and held its first meeting in Fairmont, W.Va., April 10, 1967, with 10 counties being represented by 33-member physicians and an attendance of 21 physicians, and

WHEREAS, the WVSMA and the Auxiliary to the WVSMA established a monument to honor the Founders in 1936, and

WHEREAS, the selected site for the monument was Rivesville, W.Va., where the first association president, Dr. James Edmund Reeves, practiced medicine, and

WHEREAS, the monument stands between the Rivesville City Building and a soft serve ice cream stand, and

WHEREAS, the monument if not very well kept, with weeds around the base and is constantly been vandalized and the City Government of Rivesville would like to get rid of it, therefore, be it

RESOLVED, that the WVSMA investigate moving the Founders Monument from Rivesville, W.Va., to a more appropriate location.

Resolution 4 *(Sub. Resolution 4 Adopted)*

WHEREAS, new physicians are the future lifeblood of the practice of medicine in West Virginia, and

WHEREAS, West Virginia has many opportunities for enjoyable living, and

WHEREAS, the family is very important to a practicing physician for stability, encouragement, and support, and

WHEREAS, physicians starting a practice have limited finances, therefore, be it

RESOLVED, that the WVSMA investigate with other health-related organizations, the creation of an orientation program for physicians establishing new practices in West Virginia.

Resolution 5 *(Disapproved) (This resolution is already in Policy Compendium)*

WHEREAS, vision testing is done only at the initial application for a West Virginia drivers license, and

WHEREAS, a person can now legally drive a motor vehicle for 60 years or more without verification that they can see well enough to steer their automobile safely (3,000-4,000 lbs. of steel) at speeds legally up to 70 miles per hour; therefore be it

RESOLVED, that the WVSMA seek the enactment of a mandatory law to require persons to have a vision check at the time of their drivers license renewal in

the same manner using the same criteria or better methods as are currently used to grant initial drivers licenses during the next session of the West Virginia Legislature to improve the safety and protect the property of West Virginians.

Resolution 6 *(Sub. Resolution 6 Adopted)*

WHEREAS, numerous states have enacted legislation similar to that proposed below; and

WHEREAS, there is continuing to be delays in the payment of legitimate claims filed by West Virginia physicians by many third party payors of said claims, therefore be it

RESOLVED, that the WVSMA work for the passage of legislation mandating that all clean claims submitted to third-party payors for payment be paid within 30 days of submission or be subject to an interest charge.

Resolution 7 *(Res. 7 & 8 considered together) (Amended Sub. Res. 7 & 8 Adopted)*

WHEREAS, constant change in health care indemnity or insurance has resulted in a level of complexity such that insurers are not able to field sufficient staff that are familiar with their own indemnity products, and

WHEREAS, a result of this is wrong information being given to physicians and insurees, therefore be it

RESOLVED, that due to the numerous serious concerns and frustrations of physicians resulting from unfair insurance practices, the Legislative Committee is directed to draft and to work for the passage of legislation to address the inequities in the insurance claims and reimbursement processes with specific reference to methods for identifying persons providing authorization from the insurer, and providing written confirmation to the physician of such authorization.

Resolution 8 *(Disapproved) (Included with Resolution 7)*

WHEREAS, third party payors will refuse to pay for services they have previously authorized, and will often refuse to provide promptly written confirmation of services, and

WHEREAS, written authorizations are frequently annotated with disclaimers reserving the rights of the insurer to contradict their approvals for service, therefore be it

RESOLVED, that the WVSMA apply pressure on insurers and push for legislation to mandate compliance with physician requests for non-revocable written confirmation for the authorization of specified services. In the absence of this confirmation it is legal to record the conversation with insurance representatives for the purpose of documenting what the representatives have verbally agreed to or have confirmed. *(WVSMA representatives have indicated that only one of the two parties needs to know that such recording is being made.)*

Resolution 9 *(Sub. Resolution 9 Adopted)*

WHEREAS, given the predominance of geriatrics in the State of WV and the propensity for these many patients to require multiple medications to maintain their health at a time in their life when they are ill suited to keep track of intricate medical regimens and;

WHEREAS, there has been an explosion in generic substitutions as well as the fragmentation of care brought about by the need for specialty care, and

WHEREAS, these complexities serve to diminish the oversight capacity of the physician, therefore, be it

RESOLVED, that the WVSMA consider the development of a health and safety program to educate patients to bring all their medications to their physicians.

Resolution 10 *(Amended Sub. Resolution 10 adopted)*

WHEREAS, physicians who are insured under a policy for medical professional liability provided by MEDICAL ASSURANCE, upon their retirement from active medical practice, and their desire to activate their "tail" coverage, they are required to sign an affidavit stating their intention not to engage in the practice of medicine in any form at any location, either full-time or part-time, at any time in the future, and

WHEREAS, many physicians upon retirement from their active medical practice involving direct patient care, desire to continue their role as physicians in positions that require their medical expertise, but does not involve their direct care of patients, and

WHEREAS, retired physicians are often needed to provide their expertise as consultants, or in administrative capacities, to governmental bodies, or other agencies, wherein there is no involvement with direct patient care by the physician, and

WHEREAS, physicians have the understanding that they are entitled to "tail" coverage upon their retirement, which "tail" coverage amounts to professional liability coverage for medical practice evolvement in the time period prior to their retirement date, and

WHEREAS, physicians may enter into non-patient-care related roles serving in programs under the auspices of the State of West Virginia, or other agencies, and

WHEREAS, the State of West Virginia Board of Risk and Insurance Management provides professional liability insurance for state employee physicians in the amount of One Million Dollars ($1,000,000) per occurrence, and

WHEREAS, the Legislature of the State of West Virginia has established that retired physicians, who

volunteer their services without remuneration, do not create any professional liability risk, and

WHEREAS, it is understood that any continuation of direct patient care, after a physician retires from his or her, active practice, creates a professional medical liability which is disqualifying for "tail coverage" by the primary underwriter, unless liability insurance is provided by a secondary underwriter such as that provided by the Board of Risk Management of the State of West Virginia, therefore be it

RESOLVED, that the Insurance Committee of WVSMA investigate tail coverages and report their findings to the Council at the Mid-Winter Council Meeting.

Resolution 11 *(Disapproved)(It is beyond the scope of the purposes of the WVSMA as set forth in the Constitution at Article II.)*

WHEREAS, West Virginia's economic conditions continue to deteriorate and our children and our patient's children are leaving the state to find better jobs. Our tax base continues to get eroded and our ability to pay for state, city, county government services are severely affected, and

WHEREAS, current government structure is based on archaic boundaries drawn in the days of horses, therefore be it

RESOLVED, that physicians educate their patients with a one-page letter urging them to talk to their legislators about putting forth a constitutional amendment to redraw county boundary lines to have seven large counties drawn within 30 miles driving distance of cities of Parkersburg, Clarksburg, Wheeling, Huntington, Martinsburg, Charleston, and Beckley. Thus, in effect consolidating and combining city-county governments with smaller number of elected officials and better paid service employees such as police, fire, road worker, etc. This will also reduce the number of school boards and allow for better education for children. Number of government workers should also be proportionately reduced to that comparable to surrounding state of Virginia or Ohio on a per capita basis. *The West Virginia Medical Journal* should draft and publish a letter that can be duplicated by physicians' offices to pass out to their patients.

Resolution 12 *(Amended Sub. Resolution 7)*

WHEREAS, West Virginia has one of the highest smoking rates in the nation, and

WHEREAS, West Virginia has higher mortality rates from tobacco-related illnesses than most states, and

WHEREAS, the dangers of secondary tobacco smoke exposure have been demonstrated and accepted by the public health community, and

WHEREAS, legal restrictions on smoking already exist in many public and private venues, and

WHEREAS, the WVSMA has asserted its support for smoking bans as prudent public policy, therefore be it

RESOLVED, that the WVSMA support legislation banning all smoking in public places, and support legislation limiting the use of tobacco settlement funds to (1) education concerning the health dangers in using tobacco products, (2) smoking cessation programs (3) and treatment for tobacco-related illnesses and (4) research for tobacco-related illnesses.

Cancer Committee

The Annual Meeting of the WVSMA's Cancer Committee was called to order by Chairman Catalino B. Mendoza, Jr., M.D., at The Greenbrier in White Sulphur Springs on Friday, Aug. 27, 1999, at noon during the WVSMA's Annual Meeting.

Members in attendance were: Drs. John C. Frish, Jr., James P. Carey, Graciano E. Cendana Jr., Generoso D. Duremdes and R. John C. Pearson.

Guests present were: Sushil K. Mehrota, M.D., medicl oncologist-hematologist from Wheeling; Beverly Keener, director, West Virginia Cancer Registry, Constance Harvey, program director, Breast and Cervical Cancer Screening Program/Office of Maternal and Child Health, (BCCSP/OMCH) WV Dept. of Health and Human Resources, Bureau for Public Health; and Dee Ann Price, clinical service coordinator, (BCCSP/OMCH). Guest speaker was Mike Etchemendy, oncology specialist, from Astra Zeneca Pharmaceuticals.

Minutes of the Annual Meeting held on Aug. 27, 1998, were approved as issued.

Constance Harvey presented an update on the BCCSP Diagnostic and Treatment Fund which was established by the Legislature in 1996. The fund is designed to provide financial assistance for West Virginia women who are in need of diagnostic and treatment services for breast and cervical cancer, specifically for women who meet certain income guidelines and do not have health care insurance. The fund is administered through the Office of Maternal and Child Health within the WV Bureau for Public Health. She related that the WV Bureau for Public Health, the American Cancer Society and the Mary Babb Randolph Cancer Center have invited key individuals and organizations throughout the state to become members of the West Virginia Comprehensive Cancer Control Coalition. The goal of this coalition is to create a comprehensive and coordinated cancer control in West Virginia.

The impetus for creating a comprehensive approach to cancer control in West Virginia and other states comes from the Centers for Disease Control and Prevention. Comprehensive control is simply an integrated approach to reducing the impact of cancer through prevention, early detection, treatment, rehabilitation and palliation. Harvey also announced that a Comprehensive Cancer Control Coalition Planning Retreat is scheduled to be held on September 15 and 16, 1999, at Oglebay Resort and Conference Center in Wheeling. The WVSMA Cancer Committee endorse this project and John C. Frich, Jr. volunteered to represent the committee at the retreat.

Dee Ann Price reported that the BCCSP provides statewide screening services free of charge or at a minimal fee to low income and uninsured or underinsured women. Mammography screenings are offered to women age 50 and older. Diagnostic services for breast abnormalities are available for women under the age of 50. Cervical cancer screening services are also available for women 25 and older with a PAP test. In addition, the BCCSP also educates the public and health professionals about recommended screening guidelines, breast and cervical cancer risk factors and preferred methods for performing breast self-examination. Price concluded by announcing that the month of October was Breast Cancer Awareness Month and that many events were scheduled throughout the state to raise funds such as *"Walks for Women"* and *"Quilts for Hope."*

Beverly Keener presented an update of the West Virginia Cancer Registry (WVCR). She reported on the following six items of interest:

1. The WVCR was one of 22 statewide cancer registries in the U.S. certified for excellence in completeness, accuracy and timeliness of cancer data by the North American Association of Central Cancer Registries. The certification process is conducted with funding from the Centers for Disease Control and Prevention's National Program of Cancer Registries.
2. The Bureau for Public Health has proposed a legislative rule change to require non-federal hospitals licensed for more than 50 beds to report their cancer cases in the format required by the WVCR. If a hospital does not comply with the reporting requirements, the staff of the WVCR will abstract the cases and the hospital with reimburse the WVCR for the cost of this service. The public comment period ended July 30, 1999, and only two written comments were received, both of which were in favor of the rule change.
3. Monthly progress reports of data submissions have been sent to each hospital-based registry since 1995. Due to growing problems with some hospitals having huge backlogs of cases to report, starting in May 1999, copies of these reports have also been sent to the hospital administrator and to Loretta Haddy, state epidemiologist.
4. The WVCR is currently working with Dr. Steven Jubelirer and the Charleston Area Medical Center to prepare a grant application for NCI funding for a five-year study of melanoma incidence and treatment in West Virginia. Dermatologists will be contacted to provide additional information on cases diagnosed from

1993-97 and the central registry hopes to improve reporting of this cancer through these contacts with West Virginia dermatologists.

5. The annual report containing 1993-97 incidence and mortality data should be sent to the printer in early October. If all hospitals would report in a timely manner this report could be completed six months earlier each year.
6. The WVCR now assesses approximately 11,500 cases a year and a new CTR will be joining the staff September 16. This will increase the quality control staff from one to two CTRs.

Mike Etchemendy, an oncology specialist from Astra Zeneca spoke to participants at the meeting about *"Reducing the Incidence of Breast Cancer in Women with High Risk."* He explained and demonstrated the use of the Gail Model Assessment tool, a hand-held calculator used to determine the percentage at which a patient with atypical hyperplasia is at risk for developing cancer. The Gail Model Assessment tool may be obtained, free of charge, from local Astra Zeneca Pharmaceutical representatives.

Dr. Mendoza, Jr. announced that the *"Fall Cancer Conference: Genetics and Prevention Strategies"* will be held on Friday, Oct. 15, 1999, at the Robert C. Byrd Health Sciences Center in Morgantown.

Dr. Mendoza, Jr. stated that the next Annual Meeting's time, place and date will be confirmed with a later notice. The meeting then adjourned at 1:30 p.m.

Committee on Medical Education

The West Virginia State Medical Association (WVSMA) is recognized by the Accreditation Council for Continuing Medical Education (ACCME) to accredit intrastate providers of Continuing Medical Education. WVSMA has maintained this role since 1972 and to date accredits 25 hospitals and organizations in West Virginia. The program was again re-surveyed in June 1998 and received a full four-year recognition as an accreditor from ACCME. The WVSMA was in full compliance on all of the parameters reviewed and received an exemplary commendation for the newsletter *CME Network Connections*.

WVSMA is committed to a strong CME program providing physicians with the information needed to deliver quality patient care. We host two major activities each year; the Mid-Winter Clinical Conference and Annual Meeting, as well as other small seminars and workshops. Work is continuing to organize regularly scheduled surveyor training sessions and biennial workshops for director and coordinators.

Interest has been expressed in accreditation for sponsorship of CME programs by the following: VA Hospital, Clarksburg; WV Chapter of AACE, Parkersburg; Morgan County War Memorial Hospital, Berkeley Springs; WV Bureau for Public Health, Charleston; Montgomery General Hospital, Montgomery; Plateau Medical Center, Oak Hill; St. Joseph's Hospital, Buckhannon; Wheeling Jesuit University, Wheeling; Huntington Medical Community Foundation, Huntington; and Genesis ElderCare, Morgantown. According to procedure, the following materials were sent to these organizations and hospitals interested in establishing CME accredited programs:

1. Preliminary Questionnaire
2. Application for Accreditation for CME Program
3. Essentials and Guidelines
4. Standards for Commercial Support of CME
5. Standards for CME of Enduring Materials
6. Physician's Recognition Award Information Booklet

Three on-site surveys have been conducted and five interim reports have been completed since the last Annual Report:

United Hospital Center Inc.
Survey: March 18, 1999
Surveyors: James D. Helsley, M.D., Alvin H. Moss, M.D., Nancie Albright and Shirleen Lipscomb
Recommended Award: Two-year accreditation with one-year interim report

Columbia St. Luke's Hospital
Survey: April 22, 1999
Surveyors: Warren Point, M.D., Shirleen Lipscomb
Recommended Award: Two-year accreditation with a six-month interim report

VA Medical Center
Survey: June 11, 1999
Surveyors: James D. Helsley, M.D., Shirleen Lipscomb
Recommended Award: Two-year accreditation with six-month interim report

Fairmont General Hospital
Six-month interim report

Fairmont Clinic
One-year interim report

Logan General Hospital
Six-month interim report

St. Francis Hospital
Six-month interim report

Princeton Community Hospital
Six-month interim report

An initial survey previously scheduled for Greenbrier Valley Medical Center in July was rescheduled for September.

The following 25 institutions/organizations are accredited to offer Category 1 of the Physician's Recognition Award of the AMA by the WVSMA:

Beckley Appalachian Regional Hospital
Beckley, WV

Bluefield Regional Medical Center
Bluefield, WV

Broaddus Hospital/Myers Clinic
Philippi, WV

Charleston Area Medical Center
Charleston, WV

City Hospital
Martinsburg, WV

Columbia St. Lukes Hospital
Bluefield, WV

Davis Memorial Hospital
Elkins, WV

Fairmont General Hospital
Fairmont, WV

Jackson General Hospital
Ripley, WV

Logan General Hospital
Logan, WV

Mid-Ohio Valley CME
Parkersburg, WV

Monongalia Valley Assoc. of Health Centers
(Fairmont Clinic), Fairmont, WV

Pleasant Valley Hospital
Point Pleasant, WV

Raleigh County Medical Society, CME Program
Beckley, WV

Reynolds Memorial Hospital
Glen Dale, WV

St. Francis Hospital,
Charleston, WV

St. Mary's Hospital
Huntington, WV

Thomas Memorial Hospital
South Charleston, WV

United Hospital Center, Inc.
Clarksburg, WV

VA Medical Center
Martinsburg, WV

Weirton Medical Center
Weirton, WV

WV Academy of Ophthalmology
Charleston, WV

WV Academy of Otolaryngology
Charleston, WV

WV Hospital Association
Charleston,WV

Wheeling Area CME Program
Wheeling, WV

The Committee continues to monitor each organization and its compliance with the Essentials and Guidelines and the Standards for Commercial Support and Enduring Materials set by WVSMA through annual reports and random visits. The revised Essential 7 was implemented June 1, 1998, in West Virginia. WVSMA staff has taken copies of the new essential and the new accreditation statement on each survey completed since June 1. Numerous communications have been sent to all sponsors in the year preceding.

The newsletter *"CME Network Connections"* initiated in Spring 1998 is published quarterly at the WVSMA headquarters. The newsletter has been an invaluable tool in our ongoing efforts to maintain better than average communications with our sponsors. In the short time since its inception, we have successfully invited and published articles by national CME professionals as well as articles written by WVSMA sponsors, and we plan to continue to do so. The newsletter is still mailed to CME providers, their directors and coordinators, members of the Medical Education Committee, Executive Committee and Council.

A membership/CME survey was conducted by the WVSMA to determine members' feelings about the CME program, and the Annual and Mid-Winter Meetings.

The 1998 Annual Reports were received and presented to the Medical Education Committee for review and approval.

Nancie Albright attended the ACCME State Medical Society Conference, September 18-19, 1998, in Chicago and the 1999 ACCME State/Territory Society Conference, March 5-6 in Chicago.

After 10 years with the WVSMA, Nancie Albright resigned her position as associate executive director effective April 16, 1999.

Registration Form

Name _____

Address _____ City/State/Zip _____

County _____ Specialty _____ Phone _____

Payment by: _____Check _____ VISA _____ MasterCard

Card Number _____

Expiration Date _____

Signature _____

• Cancellation Policy: There will be a $50 administrative fee for cancellations after December 15, 1999

If paying by check,
please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364
(304) 925-0342 Toll-free: (800) 257-4747
or FAX to: (304) 925-0345

To receive a special room rate, call the Embassy Suites at (304) 347-8700.

Early Bird Registration Fees — Payment must be received by Jan. 1, 2000

- ☐ **WVSMA Member — $115**
- ☐ **Non-Member — $165**

Registration Fees — After Jan. 1, 2000

- ☐ **WVSMA Member — $125**
- ☐ **Non-Member — $175**

Lunch & Learn — Saturday, Jan. 22, 2000
"Alzheimer's"
Daniel S. Foster, MD, Moderator

- ☐ **Physicians (receiving CME Credit) $50**
- ☐ **All others $35**

Total Due $_____

WEST VIRGINIA STATE MEDICAL ASSOCIATION
INST. APRIL 10, 1867

Mid-Winter Clinical Conference

Highlights

Thursday, January 20

1 p.m. -3 p.m.	Medical Assurance Loss Prevention Seminar
6:30 p.m. - 8 p.m.	**Legislative Reception**
8 p.m.	WVSMA Executive Committee Business Meeting

Friday, January 21

8 a.m. - 9:30 a.m.	WVSMA Committee on Medical Education
8 a.m. - 1 p.m.	West Virginia Medical Institute Scientific Meeting
9:30 a.m. - 11:30 a.m.	*"CME Surveyor Workshop"*
11 a.m. - 5 p.m.	WVSMA Registration
Noon	Publication Committee Meeting
Noon - 2 p.m.	Local Health Officer's Luncheon, Hosted by the Bureau for Public Health
1 p.m. - 4:30 p.m.	Exhibit Visitation
1 p.m. -5 p.m.	**FIRST SCIENTIFIC SESSION** *"Thrombolysis in Acute Ischemic Stroke"* Charles H. Tegeler, IV, MD *"Influenza"* Thomas C. Rushton, MD *"Sentinel Lymph Node Staging - Less Invasive and More Accurate"* Michael J. Edwards, MD *"Congestive Heart Failure"* William H. Carter, MD
3:30 p.m.	WVSMA Scientific & Education Sessions Committee Meeting
4:30 p.m. - 5:30 p.m.	WESPAC Board Meeting
4:30 p.m. - 5:30 p.m.	Marshall University Alumni Board of Directors Meeting
5:30 p.m. - 7 p.m.	Reception, Co-hosted by West Virginia University and Marshall University Schools of Medicine
7 p.m.	**PHYSICIAN SESSION/PUBLIC SESSION** ***"Drug Advertising/Use of Formularies"*** Charles Ryan, Moderator Harry Sweeney, Glenn Crotty, Jr., MD, and Kevin Yingling, MD

Saturday, January 22

7:30 a.m. - 8:30 a.m.	WVSMA Surgery Section Breakfast Meeting
8:30 a.m. - 5 p.m.	Exhibit Visitation/Registration
8:30 a.m. - 4:30 p.m.	WVSMA Medical Student Section Meeting and Luncheon
9 a.m. - Noon	**SECOND SCIENTIFIC SESSION, "Controversies in Medicine"** *"Prostate -- PSA Screening Diagnosis"* *"PSA -- Uses and Abuses"* Rocco A. Morabito, MD *"PSA -- Technology Before Wisdom"* Shawn A. Chillag, MD *"C-Section /V Back"* Speakers to be Announced
10 a.m. -3 p.m.	WV Urological Society Meeting
Noon - 4 p.m.	WV Psychiatric Association
Noon - 2 p.m.	WV State Society of Anesthesiologists
Noon - 1:30 p.m.	**Lunch & Learn - *"Alzheimer's"*** Daniel S. Foster, MD, Moderator; James P. Griffith, MD; Mark A. Newbrough, MD
1:30 p.m. - 5 p.m.	**THIRD SCIENTIFIC SESSION, "Palliative Care"** Introduction and Case Presentation *"I Feel Like a New Person"* *"Treating the Patient in the Final Hours"* Sue C. Warren, MD, FACP *"Communicating Bad News to Patients and Families"* Stephen C. Hines, PhD *"The Ethics and Law of Pain Management"* Alvin H. Moss, MD Case Discussion and Question and Answer Session
7 p.m. - Midnight	Special Entertainment Event

Sunday, January 23

7 a.m.	WVSMA Council Breakfast Meeting
8:30 a.m. - 11 a.m.	Exhibit Visitation/Registration
9 a.m. - Noon	**FOURTH SCIENTIFIC SESSION, "Potpourri of Topics"** *"Diabetes in the New Millenium: Approaching the ADA Standards of Care"* Frank L. Schwartz, MD *"Bipolar Disorders"* Kenneth H. Fink, MD *"Stump the Audience"* Robert J. Marshall, MD, Warren Point, MD, Moderators James E. Brick, M.D., Derrick L. Latos, M.D., Presenters

Special Article

WVMI dedicates building to visionary founder, Harry S. Weeks, Jr., M.D.

The West Virginia Medical Institute (WVMI) dedicated its headquarters on Sunday, Sept. 26, to the late Harry S. Weeks, Jr., M.D., a nationally prominent physician and past president of the WVSMA who helped found the non-profit peer review organization in 1973.

The ceremony began with a welcome address by Mabel M. Stevenson, M.D., president of the WVMI Board of Trustees, and the reading of a proclamation from Senator Jay Rockefeller by Wes Holden from the senator's office. After remarks by Richard G. Starr, M.D., secretary of the WVMI Board of Trustees, and Carl J. Roncaglione, M.D., a past president of the WVSMA, a bronze plaque was unveiled honoring Dr. Weeks and a plaque was presented to his wife, Esther Weeks.

Harry S. Weeks, Jr., M.D.

A national leader in medical peer review, Dr. Weeks sought to improve the quality of health care in West Virginia and across the nation. He was instrumental in writing the laws that govern the quality oversight of the Medicare program in the early 1970s, and when Medicare required a state quality review program, Dr. Weeks established the WVMI. He served as its president and medical director for 22 years.

While he was president and medical director of WVMI, Dr. Weeks maintained a full-time anesthesia practice at the Ohio Valley Medical Center in Wheeling. In addition to his dedication to WVMI, Dr. Weeks served the WVSMA as president from 1971-72, and was an alternate delegate and a delegate to the AMA for a total of 20 years. He also served as chairman of the Committee on Medical Economics and the Joint Conference Committee.

During his career, Dr. Weeks was a member of the West Virginia Board of Medicine for 23 years. He was vice president of that body for six years, and was a personal medical affairs advisor to several governors. Dr. Weeks also served as president of the Ohio County Medical Society and of the medical dental staff at the Ohio Valley Medical Center. He was a Fellow of the American College of Anesthesiologists, a Diplomat of the American Board of Anesthesiologists and a clinical professor of anesthesiology at the WVU School of Medicine.

Dr. Weeks died on Jan. 7, 1997, at the Ohio Valley Medical Center of cancer. A native of Clarksburg, he served in the U.S. Navy after high school from 1944-46, and then as an officer in the Naval Reserve. He graduated from WVU in 1949 with an A.B. degree and then from the University of Maryland School of Medicine in 1953. He interned at Mercy Hospital in Baltimore and completed his residency in anesthesia at Ohio Valley General Hospital in Wheeling.

Mabel M. Stevenson, president of the WVMI Board of Trustees, presents Esther Weeks, with a plaque honoring her late husband, Dr. Harry S. Weeks, Jr., the founder of the WVMI. Receiving the plaque with Mrs. Weeks is her daughter, Karla.

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Latex allergy causes problems in health care setting

Q. What can medical professionals do to decrease both patient and personal risks of developing a latex allergy?

A: Although less than one percent of the general public is at risk for developing a latex allergy, researchers say medical professionals have a greater chance of developing such an allergy. Approximately 10%-20% of all health care workers are believed to be latex sensitive. Every time medical professionals change gloves, they increase the possibility of becoming more susceptible. Symptoms can include watery eyes, hives, dizziness, asthma, sneezing, abdominal cramps, low blood pressure and anaphylaxis.

The following suggestions may help to decrease the risk of developing a latex allergy:

- Use non-latex gloves when you aren't likely to come in contact with infectious materials. If you must use latex gloves, use powder-free gloves with reduced protein content.
- Avoid using oil-based hand creams or lotions when wearing latex gloves. These products can cause the gloves to deteriorate and may release additional allergens into the air.
- After removing the gloves, wash hands with a mild soap and dry thoroughly.
- Know the signs and symptoms of a latex allergy.

Risk Management

Risk management/legal experts also suggest the following actions to help reduce liability associated with latex allergies:

- A patient's known and potential allergies should be documented in the medical record.
- Any effort to provide safe, latex-free care should be documented in the patient's medical record.
- Staff should be alerted regarding the patient's allergies.
- In a hospital setting, the patient should be flagged and the patient should wear a medical-alert wristband.
- Latex-free gloves and equipment, as well as a latex-free crash cart, should be kept on hand.

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Planning for scholastic cardiac emergencies: The Ripley Project

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Abstract

Fatalities during sports participation are usually cardiac in origin. Sudden Cardiac Arrest (SCA) from ventricular fibrillation has been reported in several sporting venues over the last decade. Successful treatment of stadium SCA requires a rapid response team equipped with defibrillator capabilities. The use of automated external defibrillators (AED) by responders in sports arenas is critical to help prevent catastrophic scholastic athlete and spectator cases of unexpected sudden cardiac death.

Introduction

High school athlete medical coverage has received increasing emphasis over the past decade. Mandatory pre-season physical examinations have been standarized and expanded to detect athletes at risk for emergency medical conditions (1).

Many school systems now employ full-time certified athletic trainers for year-round sporting event coverage. In West Virginia, the State Board of Education requires all high schools participating in interscholastic football to have an athletic trainer present at all practices and games.

For the last 10 years, the Sports Medicine Committee of the West Virginia Chapter of the American Academy of Family Physicians (WVAAFP) and the West Virginia Secondary Schools Activity Commission (SSAC-the state governing body of scholastic sporting events) has monitored event coverage utilizing a report card system. Prior to kickoff, documentation of "on the field" athletic trainer, ambulance, and team physician attendance is recorded for future analysis.

The coach's role in injury prevention and emergency response has also expanded in scope. The National Federation of High School Sporting Associations routinely conducts workshops and seminars to enhance the health care of the student athlete. This includes safe wrestler weight loss, preventative programs for anabolic steroid abuse, and catastrophic health and neck injury prevention.

In West Virginia, the SSAC conducts mandatory pre-season programs on injury management provided by the Sports Medicine Committee of the WVAAFP and representatives of the West Virginia Athletic Trainers Association (WVATA). Coaches are encouraged to maintain a current CPR certification. The American Heart Association (AHA) recommends the Heart Saver classification of certification for all individuals responsible for adolescent emergency care. To maximize outcomes, automated external defibrillator (AED) training was incorporated by the AHA in the fall of 1998.

Sudden cardiac arrest

Sudden cardiac arrest (SCA) has an estimated annual incidence of 0.7 to one per 1,000 population (2,3). High school athlete sudden death is rare; however, sudden cardiac arrest in adult spectators has been reported (4,5). In fact, one of these unfortunate incidents occurred at a major college basketball game when the first author of this article was in attendance.

Professional and collegiate sporting venues typically employ emergency medical response teams for spectator care coverage. High school event coverage is less organized and typically falls under the responsibility of the athletic director or school administrators.

The entry of automated external defibrillators into the sporting arenas has become attractive as the result of numerous studies documenting increased survival rates with police and first responder programs (6,7). In addition, the AHA has endorsed the newly introduced, sophisticated, safe and relatively inexpensive AEDs for targeted

responder groups. At the 1998 National Athletic Trainer Association (NATA) meeting in Baltimore, Md., most NFL trainers reported utilizing AEDs.

On the collegiate level, officials from the Southeastern Conference documented eight of 12 member schools with plans to provide AED coverage at practice and games in the upcoming school year. The University of Georgia initiated a program in 1997 which has become a model for other member schools. This program is designed for time to shock under five minutes from deployment, from one of the three training rooms equipped with Lifepak 500 AEDs.

Several high school trainers attended the AED workshop at the Baltimore convention. Many expressed a keen interest for incorporating AEDs into their existing emergency event coverage; however, no existing high school AED programs were reported.

The Ripley Project

High school sporting events traditionally enjoy a high priority in rural communities. In many locations, the high school campus becomes a focal point for public gatherings and a potential site for cardiac emergencies (8).

In Jackson County, W.Va., the Board of Education operates two high schools with an average enrollment of 1,200 students. During the summer of 1997, the Board approved the purchase of two Lifepak 500 AEDs for deployment at high school sporting events. This action was prompted by encouragement from Emergency Department personnel at Jackson General Hospital, located in Ripley, in response to a case of SCA in a 16-year-old high school baseball player in an adjacent county. This student had died when he was struck in the chest by a baseball from 90 feet as he attempted to slide into third base. Commotio Cordis (cardiac concussion) was the expected cause of death.

Prior to the start of fall football practice, school administrators invited each appointed high school football trainer and coaching staff to attend a CPR re-certification and AED workshop. This five-hour course was conducted by staff from Jackson General Hospital, local Emergency Medical Services personnel, and the regional EMT coordinator. It was attended by the hospital's AHA coordinator and nurses from the Emergency Department, as well as 26 school personnel, including various head coaches and principals.

The course was actually modeled from a casino responder program which was initiated in select Las Vegas properties during early 1997. Components of initial education included emphasis on signs and symptoms of pending cardiac arrest and video CPR instructions. All students were tested in one person CPR by AHA instructors prior to AED inservice and subsequent testing. Continuing education at three-month intervals was facilitated by impromptu drills during scheduled team practice and Faculty Senate Day teacher workshops combined with a quarterly newsletter with an educational focus.

The Ripley pilot project received endorsement from the State Board of Education and prior to initiation of the project, the West Virginia Legislature approved a grant providing funding for the placement of three additional AEDs to first responder fire department units in strategic county locations. Members from the educational team for the coaching inservice also provided education for local fire departments.

Reports indicated that Jackson County was among the first school systems in the U.S. implementing early defibrillation programs (9,10).

Discussion

Most cases of indirect fatalities during sports play are cardiac in origin (11). In addition to structural and congenital causes precipitating SCA, the syndrome of cardiac concussion has received recent attention (12,13,14,15). A laboratory model of commotio cordis reported by the Cardiac Arrhythmia Services at Tufts New England Medical Center has defined late repolarization induced ventricular fibrillation as "the insult in Little League baseball" (16).

Although the incidence of SCA in the athletic arena is low, the impact on a community is devastating when a young, vibrant, apparently healthy athlete succumbs to sudden death during sports play. The recent availability of automated external defibrillators has provided a mechanism to prevent such loss.

The decision to investigate the feasibility of early defibrillation programs at the local high school should consider the strength and motivation of current community CPR initiatives. School administrative personnel can structure sports team AED purchase with student CPR classroom teaching justification. Good citizenship mandates early defibrillation awareness during initial CPR teaching exposure.

Medical supervision for targeted responder AED program is an essential component of success. Emergency Department personnel are traditionally in charge of the community cardiac emergency response and can provide invaluable insight into early defibrillation programs. Initial organization must include coordination with existing pre-hospital care providers to maximize survival rates. Adherence to the AHA chain of survival concept must be strictly enforced (1,2). The addition of a cellular phone to the AED carrying case is ideal for rural settings to promote 911 activation prior to initiating resuscitation.

The chain of survival includes:

1. Fast EMS activation (call 911);
2. Early CPR by a first responder (target responder);
3. Early defibrillation (the greatest single impact on survival statistics);
4. Early advanced life support (such as intubation, external pacing and cardiac medications); and
5. Late advanced life support involving dwelling pacemakers and defibrillators, medications and surgery (17).

Quality assurance issues can be facilitated by critical review of AED usage provided by data display programmed into newer AED units. Emergency Department physicians anticipated to be utilized in the event of cardiac emergency should be incorporated into plans for the initial course and subsequent continuing education at three-month intervals. This concept must also be augmented with excellent cellular phones or radio communication in rural areas.

Conclusion

Recent technological advances in automated external defibrillator equipment design provide an opportunity for advanced treatment to become safe and expedient in the hands of targeted responders. As a result, communities need to develop a mechanism for education and equipment acquisition.

Historically, most communities support local schools for noteworthy projects. Additional grant funds are currently being sought for additional studies in an even more rural West Virginia county. Physician directed CPR and AED training for teachers, coaches, school administrators, and athletic trainers provides an attractive model for improving the safety of athletic participation and spectator safety at athletic events.

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A study of the future practice location intent of family medicine residents in West Virginia

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Abstract

Recruitment of graduating family medicine residents into practice in rural West Virginia has been hampered by many factors. A cross-sectional survey was done to obtain the opinions of family medicine residents in West Virginia in 1996 in order to characterize their perceptions regarding certain aspects of their rural training and the relative importance of various factors influencing their future practice location intent. There was a positive association between cumulative resident experience and intent to practice in West Virginia and in rural areas. Perceived preparation for rural practice varied with educational area. There was significant variation in the relative importance of recruiting factors for likelihood of practice in West Virginia and in rural areas. Some recruiting factors tended to be positive or negative discriminators for intent to practice in West Virginia and in rural areas. Enhanced recruitment may be aided by an active community involvement which addresses the identified relevant factors.

Introduction

Recruitment and retention of health care providers in rural underserved areas have been difficult problems which contribute to a sub-optimal health care delivery in West Virginia and much of Appalachia (1,2,3).

Factors which have impeded recruitment and retention are numerous, and have included cultural factors (1,4), workload (5,6), lack of familiarity with or inadequate training for local health care demands (1,7), lack of financial incentives (5,8,9,10), lack of family support (4,11,12,13), and inadequate recruitment effort and colleague support (13). Training programs have not always addressed these problems which the graduating prospective provider may face in a rural location nor have they uniformly assisted the provider in the transition from an academic to a rural setting (7,14,15).

The subject of recruitment to rural areas is especially pertinent to the discipline of family medicine since family physicians comprise the majority of rural physicians. Recruitment of family medicine residents in West Virginia may be influenced by a variety of factors which have been partially identified (16) but not quantified.

A survey of family medicine residents in West Virginia was conducted in 1996 in order to:

1) estimate the number of residents planning to practice in West Virginia and in rural areas;
2) study the association between cumulative clinical experience and plans to practice in West Virginia and in rural areas;
3) quantify resident perception of preparation for certain aspects of rural health care delivery and practice; and
4) characterize the relative importance of various factors affecting resident decisions regarding practice location.

Methods

A questionnaire was developed which asked individual family practice residents to quantify their rural preparation in various educational areas and also the importance of various cultural, financial and professional factors influencing their decision whether to practice in West Virginia and in a rural area. Residents were also asked to check their year of training and the status of their current plans to practice in West Virginia and, separately, in a rural health professional shortage area.

Since West Virginia is largely a rural state with no large cities, a rural community was defined as one with a population less than 2,500. A map of the state showing health professional shortage areas was enclosed with the survey.

Respondents rated their preparation for rural practice from 1 (no preparation) to 5 (excellent preparation) in certain training areas chosen as being among those relevant to the prospective rural practitioner by frequently requiring expertise in the absence of consultants. In selecting factors which would or did influence the decision whether to practice in West Virginia or a rural area, residents were asked to quantify relative importance of listed factors from 1 (no importance) to 5 (great importance).

The questionnaires were mailed in April 1996 to all 110 family medicine residents enrolled in the training programs at West Virginia University in Morgantown and Charleston, at Marshall University in Huntington, and at community hospitals in Wheeling and Clarksburg. Follow-up forms questionnaires were sent to non-responders in June 1996. Residents were informed that responses were confidential and voluntary and that they were not required to answer every question.

Table 1. Perceived preparation for rural health care practice.

	Score*
Obstetrics	3.06±1.09
CCU/ICU	3.40±0.87
Orthopedics	2.66±0.89
Emergency care	3.86±0.87
Preventive health	4.17±0.95
Practice management	3.39±1.04
Managed care	3.49±1.02
Procedure	3.22±0.97

(Mean Score + SD, possible range 1 (no preparation) - 5 (excellent preparation).

All returned responses were entered into the data tabulation regardless of the completeness of the form.

Results

Survey forms were returned by 19 first-year residents, 28 second-year residents and 26 third-year residents, for a total of 73 responses, or 66.3 percent of those mailed. The overall mean scores for perceived preparation for various aspects of rural health care delivery are shown in Table 1.

The highest rating was for the area of preventive health and the lowest was for orthopedics. There was no statistically significant association found between residency location and plans to practice in West Virginia or in a rural area. There was a statistical association, for all programs combined, found between year of residency and likelihood of practicing in a rural area ($P = 0.02$) and in West Virginia ($P = 0.04$), with third-year residents more likely to answer affirmatively. There was a trend, not statistically significant, for association of planning to practice in West Virginia and in a rural area ($P = 0.14$).

Table 2 shows the mean scores of respondents regarding the relative importance of various factors involved in their decision of practice location, categorized by the likelihood of practice in West Virginia. For the "Yes" respondents, the factors receiving the highest scores were family ties, familiarity with the geographic area, existing practice availability, spouse/family influence and lifestyle factors. The "No" respondents selected spouse/family influence, lifestyle, cultural factors, medicolegal climate and on-call support as most important. The factors which would most influence the decisions of the undecided group are lifestyle, spouse/family influence, colleague support, educational system and on-call support.

Factors which discriminate among the three groups were found to be geographic familiarity, practice availability, medicolegal climate and educational system. Geographic familiarity and practice availability differed significantly among the groups with the "Yes" group (planning to practice in West Virginia) rating these factors significantly higher than did the other two groups. There was a highly significant difference among the groups in regard to concern over the medicolegal climate, with only those least concerned tending to remain in the state. There was also a significant difference among the groups concerning the educational system, with the "Yes" respondents rating this factor significantly lower than did the undecided group.

The relative importance of listed factors, categorized by the likelihood of practice in a rural area, is shown in Table 3. The "Yes" respondents were most concerned with spouse/family support, familiarity with the local area, existing practice availability, and scope of practice. The "No" respondents gave highest mean scores to spouse/family support, on-call support, colleague support, financial factors, scope of practice, education system, and consultation availability. For the decision of the "Uncertain" group, important factors are scope of practice, colleague support, cultural factors, existing practice availability, and spouse/family support.

In discrimination among the three groups regarding intent of rural practice, important factors were colleague support, spouse/family influence, educational system, on-call support and consultation availability. There was a significant difference for the factor "colleague support," with the "Yes" group rating this factor significantly lower than did the "No" group. A significant difference also existed in regard to spouse/family influence with the "No" respondents rating this factor significantly higher than did the other groups.

The importance of the educational system and of consultation availability were significantly less for the "Yes" group than for the "No" group. The "Yes" respondents rated the importance of on-call coverage significantly lower than did the other groups.

Discussion

Since 47 percent of the responding residents indicated their intent to practice in West Virginia and 23 percent were uncertain, it seems likely that the majority of 1996 family medicine residents will initially practice in this state. Figures for intent to practice in rural areas are not as high, with 36 and 26 percent for the two groups, respectively. These figures compare favorably with the national average of 3.8 percent for graduating family practice residents with the intent to practice in a rural area or town with population less than 2,500 (17). For comparison, it is noted that present figures show that approximately 68 percent of West Virginia physicians are located in the eight most urban counties (18).

In regard to perceived preparation for rural health care

Table 2. Importance of recruiting factors categorized by likelihood of practice in West Virginia.

Factor	Yes(N)	No(N)	Unc(N)+	P
Family ties	4.03(30)	3.06(17)	2.92(13)	0.07
Familiarity with geographic area	3.93(29)	2.67(18)	2.64(14)	<0.01*
Existing acceptable practice availability	3.90(29)	2.94(17)	3.00(14)	<0.01*
Colleague support	3.07(29)	2.88(17)	3.71(14)	0.16
On-call support	2.57(28)	3.25(16)	3.47(16)	0.09
Spouse/family influence	3.83(30)	3.79(19)	3.73(15)	0.98
Moonlighting experience	2.43(28)	2.24(17)	2.54(13)	0.83
Financial factors	3.04(28)	3.13(16)	2.86(14)	0.88
Scope of practice	2.96(27)	3.00(16)	2.92(12)	0.99
Medicolegal climate	1.89(27)	3.31(16)	3.08(12)	<0.01*
Cultural factors	2.86(28)	3.35(17)	3.20(10)	0.44
Education system	2.29(27)	3.06(17)	3.62(13)	<0.01*
Lifestyle factors	3.79(29)	3.53(17)	4.00(15)	0.50
Government factors	1.75(28)	2.41(17)	2.40(10)	0.11
Recruitment effort	2.25(28)	2.47(17)	3.00(11)	0.28
Other	1.00(2)	5.00(3)	5.00(1)	

Mean score (sample size), possible range 1 (no importance) - 5 (great importance).

** statistically significant*
+ Unc - uncertain

delivery and practice, scores for categories other than preventive health were in the mid-range. This may indicate that residents believe that they could receive more instruction or experience for independent practice in some disciplines, e.g., obstetrics and orthopedics in this study, and this perception may contribute toward a feeling of insecurity regarding their ability to provide rural health care services. These are measures of perceptions of preparation, rather than actual preparation, and may vary with individual, length of time in training, and interests. It is the perception of preparation, however, which contributes to the inclination toward rural practice and which affects the perception of relative importance of various recruiting factors. It should be pointed out that the choice of certain training areas, of the many possibilities available, can influence the results of this analysis. The association between time in training and intent to practice in a rural area may reflect increasing confidence in training and ability with training experience, attesting to the overall effectiveness of the programs in training rural practitioners.

A cooperative response by academic programs and communities in addressing important recruiting factors is one method of possible enhancement of future recruitment of new family practitioners and their spouses. The community role may be particularly important in addressing the family and spouse concerns. Since a positive association was noted between progressive training (and, presumably, progressive rural exposure) and intent to practice in rural areas, it may be possible to address the concerns of the significant numbers of "No" and "Uncertain" respondents by programs that expose the resident and spouse to specific rural sites periodically throughout the training period so that issues such as education, lifestyle, on-call support, consultation, etc., can be addressed by a concerted community effort during a more extensive period of familiarization. These and other efforts may emphasize the role of rural communities in recruitment and result in improved recruitment skills. Such community efforts can play a vital role in recruitment (13,19,20).

There are some limitations to interpretation and application of this study. It is based on responses of two-thirds of the family medicine residents in West Virginia in 1996 and it may not be relevant to the entire resident population or to other time periods. The evaluation of resident perception toward adequacy of rural training in the listed training areas does not necessarily extend to broader subject areas not listed. The response to evaluation of training areas and of recruiting factors was somewhat less complete for first-year residents and opinions of these less experienced residents are under-represented here. The designation of a rural community as one with population less than 2,500, rather than a higher figure, may have affected responses.

Table 3. Importance of recruiting factors categorized by likelihood of practice in a rural or underserved area.

Factor	Yes(N)	No(N)	Unc(N)‡	P
Family ties	2.78(23)	3.56(18)	2.50(14)	0.21
Familiarity with local area	3.22(23)	3.63(19)	3.07(14)	0.53
Existing practice availability	3.17(23)	3.74(19)	3.40(15)	0.43
Colleague support	2.91(23)	3.95(18)	3.71(14)	0.03*
Spouse/family support	3.45(22)	4.58(19)	3.36(14)	0.01*
Moonlighting experience	2.23(22)	2.69(16)	2.29(14)	0.59
Scope of practice	3.14(21)	3.81(16)	3.92(12)	0.14
Cultural factors	2.68(22)	2.67(15)	3.67(12)	0.11
Education system	2.05(22)	3.69(16)	3.08(13)	<0.01*
Financial factors	3.00(22)	3.88(17)	3.33(15)	0.16
On-call coverage	2.23(22)	4.05(19)	3.21(14)	0.01*
Social service support system	2.36(22)	3.06(17)	2.92(13)	0.21
Consultation availability	2.41(22)	3.67(18)	2.92(13)	0.01*
CME availability	2.27(22)	3.00(17)	2.31(13)	0.15
Governmental factors	2.35(20)	2.36(14)	2.46(13)	0.97
Recruitment effort	2.10(20)	3.13(15)	2.54(13)	0.13
Other	1.00(1)	(0)	1.00(3)	

Mean score (sample size), possible range 1 (no importance) - 5 (great importance).

** statistically significant*
‡ Unc - uncertain

Other inherent limitations include subjective variation in interpretation of categories and variation of clinical experience by respondents. The assignment of a high score to a certain recruiting factor does not necessarily indicate whether the factor was highly positive or negative in recruitment; the reader must interpret this. However, the association of these factors with likelihood of practice in West Virginia and in rural areas, and the designation of some factors as significant positive or negative discriminators helps to minimize the latter limitation.

Conclusion

A majority of family medicine residents in West Virginia surveyed during 1996 seemed likely to practice in the state. Figures were not as high for intent to practice in a rural area. Respondent ratings for rural preparation in various educational areas tended to be in the mid-range with preventive health having the highest score and orthopedics the lowest.

Length of training was associated with increasing likelihood of practice in West Virginia and in rural areas. In regard to intent to practice in the state, those predictive positive factors were familiarity with the geographic area and practice availability; those negatively associated, and potential areas for improvement, were the medicolegal climate and the state educational system. Those residents who do not anticipate practice in a rural area place more value on the following factors: spouse/family support, education system, on-call coverage, and consultation availability. Some of these latter factors may be addressed to increase the number of prospective recruits to rural areas and increased community participation in this process is desirable.

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(Please contact first author for other references listed in this article.)

Cow's milk allergy in infants

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Abstract

Cow's milk allergy (CMA) is one of the most common food allergies in young infants affecting up to 7% of children less than six months of age. The clinical presentation of these infants may be very traumatic to their parents, as significant rectal bleeding is the most common symptom in this disease. This article describes our experience treating 44 infants who were diagnosed with CMA in the Pediatric Gastroenterology Clinic at Marshall University. The clinical symptoms, treatment and outcome are presented. To reduce apprehension from the parents, primary physicians should be familiarized with this disease.

Introduction

Cow's milk allergy (CMA) is one of the most common food allergies in young children affecting between 2% and 7.5% of infants (1-3). The immaturity of the intestinal mucosa, the low level of serum IgE, coupled with increased gut permeability, put infants at risk for increased allergy.

CMA is common in children before their first year of life. Symptoms may include mucoid diarrhea, vomiting, bloody stool, abdominal pain, and failure to thrive. Non-gastrointestinal symptoms may also be presented including wheezing, rhinorrhea, eczema, and anaphylaxis (4,5). In older infants, CMA may present itself with anemia due to chronic fecal blood loss (6).

Fortunately, CMA in children is a self-limited disease which often resolves when a child reaches two to three years of age (5,7). Immunologic diagnostic tests (i.e.: serum IgE, peripheral eosinophilia, mucosal eosinophils, RAST test), were previously shown to help in the diagnosis of CMA, but these tests do not have adequate accuracy rates. Accordingly, the diagnosis of CMA is predominantly made by clinical observation and dietary manipulation.

In this study, we review our experience with 44 patients diagnosed with CMA in the Pediatric Gastroenterology Clinic at Marshall University from 1993-97.

Material and methods

The charts of all children diagnosed with CMA in the Pediatric Gastroenterology Clinic were retrospectively reviewed and the demographic, laboratory, and clinical data were collected.

In order to locate non-compliant patients, telephone calls were made to the patients' home or to their primary physician offices, to examine their clinical outcome. The calls were made after the completion of data collection.

Results

A total of 44 patients were diagnosed with CMA between 1993-1997. The demographic data and clinical presentation is demonstrated in Table 1.

Overall, the mean age of diagnosis was 3.6 months, and rectal bleeding was the most common clinical presenting symptom. Laboratory results are shown in Table 2.

Peripheral eosinophilia was found in only two patients. Rectal biopsy was performed only in four patients of whom three showed mucosal eosinophilia.

Clinical outcome

Dietary manipulation of all patients is seen in Table 3. Breast milk was continued in four infants (40%), soy-based formula was initially tried in 17 patients and elemental formula (Nutramigen and Alimentum) was given to 23 infants. Four patients (24%) who received soy-based formula did not respond and were changed to elemental formula successfully.

Clinical follow up was available in 22 infants (50%). The mean follow-up period was 8.2 months (range: 6-12 months). Of these patients, eight were younger than 12 months of age. CM challenge test was clinically performed in 14 children at 12-13 month of age (nine by us and five by their parents or primary physician).

Twelve patients (85%) tolerated CM protein and were then able to consume milk products. A total of 22 patients failed to follow up with

Table 1. Clinical symptoms.

# of patients	44
Male/Female ratio	1.9:1.0
Bloody stool	35 (79.5%)
Gross	27 (61.3%)
Occult	8 (18.1%)
Diarrhea	17 (38.6%)
Abd. pain/irritability	12 (27.2%)
Vomiting	10 (22.7%)

Table 2. Laboratory results.

Item	# Patients	Result
Hb	39	11.5 + 1.6g%
Eosinophils	37	2% (0-27%)
Protein (total)	26	5.6 + 0.8g%
Albumin	26	3.7 + 0.5g%
Rectal biopsy	4	1-normal, 3-eosinophils

Table 3. Dietary treatment.

Diet	# Patients	Success Rate
Soy-based	17	13 (76%)
Nutramigen	20	20 (100%)
Alimentum	3	3 (100%)
Breast milk	4	4 (100%)
Total	44	94% (mean)

the Gastroenterology Clinic and were contacted by telephone. Three were asymptomatic and fed a CM-containing diet, three were on CM-free formula, and 16 patients could not be contacted because they were no longer being followed by their primary physician and/or their phone service had been disconnected.

Discussion

CMA is one of the most common allergies in young infants and is defined as an allergic reaction to cow's milk proteins. The clinical presentation of CMA may include a wide spectrum of symptoms involving respiratory, dermatologic and/or gastrointestinal symptoms.

In this study, we showed that most of our patients were diagnosed by the first six months of their life. In most cases, the final diagnosis was established by clinical suspicion and diet manipulation, while laboratory evaluation was not helpful. Previous data have shown that 30% to 50% of infants with CMA are also allergic to soy-based formula (8,9). Concurring with these results, 23% of our patients failed to respond to soy-based formula, but responded to elemental formula. Our data may suggest that elemental formula may be better as an initial dietary choice for infants with CMA who are less than three months of age.

Interestingly, CMA was diagnosed in 10 infants (22.7%) who were exclusively breastfeeding. In mothers who chose to continue breastfeeding, their infants improved after milk products were eliminated from the mothers' diet. CMA in babies who were exclusively breastfeeding has been previously reported (10,11). Previous data have shown that beta-lactogloblin may be secreted in the breast milk of lactating mothers who consumed milk products, even up to several days after milk elimination (12,13). We suggest that a complete dietary intake be done in mothers who are breastfeeding infants with CMA.

Since most patients will tolerate CM protein by two to three years of age (5,7), CM protein challenge should be routinely considered during dietary restriction. It was previously recommended that CMA be diagnosed and followed by multiple intestinal biopsies pre- and post- milk protein challenge test (14). This recommendation has now been abandoned and a CM protein challenge is currently performed by clinical response to the protein intake. Nevertheless, there is no standard protocol for CM protein challenge procedure and different protocols have been reported (5,15).

The immunologic response after CM protein challenge has been traditionally divided into two main categories: immediate allergic response and late allergic response (16). In the immediate response, severe anaphylaxis can develop within a few hours and lead to an acute life-threatening event. In the late immunologic response, allergic symptoms such as wheezing, skin rash and gastrointestinal symptoms may appear after a few days or weeks. This reaction is usually milder and is not life threatening. Accordingly, it is recommended that a CM protein challenge test be performed where medical supervision is readily available. In our study, a CM protein challenge was performed in 14 patients of whom only 10 were performed under medical supervision. In four patients (28%), the parents had challenged their infants by giving them milk products without medical instructions or supervision. Such experience is a common finding, since many infants are fed by other family members (relatives, babysitters, siblings, etc.) who are not aware of their dietary restrictions. Parental education of the emergencies that could develop with uncontrolled CM protein challenges, may help to avoid such practices.

We acknowledge the poor follow-up rate observed in our study. In spite of telephone calls to their homes or their primary physicians' offices, we were unsuccessful in locating many patients. Most of our patients receive their formula through the WIC program. To receive special formula, medical authorization is needed. Since many of the non-compliant patients did not follow with us and/or their primary physicians, we believe that they were switched to CM containing diets by their caretakers without side effects. It is also possible that some of these patients were relocated or exchanged physicians without notifying us or their primary physicians.

Conclusion

In summary, we report our experience of young infants who were diagnosed with CMA. We believe that the diagnosis can be easily made by clinical suspicion and diet manipulation. Specific and expensive immunologic lab tests are seldom needed and are usually not helpful.

CM protein challenge test should be performed cautiously and with medical facilities close by.

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At Mid-Winter

Thrombolysis, influenza, lymph node staging, congestive heart failure topics for First Session

The First Scientific Session at this year's WVSMA Mid-Winter Clinical Conference at the Embassy Suites in Charleston will feature four lectures pertaining to the fields of neurology, infectious diseases, surgery and cardiology. This session will be presented on Friday, January 21 at 1 p.m., and will be moderated by **Daniel S. Foster, M.D.**, chairman of the Mid-Winter Clinical Conference.

"Thrombolysis in Acute Ischemic Stroke," is the title of the first lecture which will be delivered by **Charles H. Tegeler, IV, M.D.,** a professor of neurology at Wake Forest University School of Medicine. After Dr. Tegeler's lecture, **Thomas C. Rushton, M.D.**, chief of the Section of Infectious Diseases at the Marshall University School of Medicine, will discuss *"Influenza."*

Following a break, this session will reconvene with a lecture on *"Sentinel Lymph Node Staging — Less Invasive and More Accurate"* by **Michael J. Edwards, M.D.**, associate professor of surgery at the University of Louisville. The final lecture for this session will be given by Charleston cardiologist **William H. Carter, M.D.**, on the topic of *"Congestive Heart Failure."* After Dr. Carter's presentation, the four speakers will form a panel for a question and answer session.

Biographical information about these speakers begins below. A registration form and a preliminary program for the meeting is printed in this issue on pages 251-253.

For more details or to register by phone, please call the WVSMA at (304) 925-0342. To contact the Embassy Suites for room reservations, dial 1-800 Embassy or 347-8700.

Tegeler

Edwards

Carter

Speakers highlighted

Dr. Tegeler received his M.D. degree in 1979 from the University of Missouri - Kansas City School of Medicine, where he also completed a residency in internal medicine.

From 1982-85, Dr. Tegeler did a residency in neurology at the University of Texas Health Science Center in San Antonio. After his residency, Dr. Tegeler became an instructor at the University of Texas Health Science Center and two years later was promoted to assistant professor.

In 1990, Dr. Tegeler relocated to Winston-Salem, N.C., to join the faculty at the Wake Forest University School of Medicine as an assistant professor of neurology. He was named an associate professor in 1992, and this year accepted his current post as a professor of neurology. In addition, to being a professor, Dr. Tegeler is head of the Section on Stroke and Cerebrovascular Disease and director of the Neurosonology Laboratory at Wake Forest.

Dr. Tegeler's major focus for research and teaching is in the areas of stroke and neurosonology, and he has been very active in clinical stroke prevention and treatment trials. The co-author of the textbook *Neurosonology,* Dr. Tegeler has published over 159 book chapters, journal articles and abstracts. He is the editor of the *American Society of Neuroimaging Newsletter* and a manuscript reviewer for *Stroke, Archives of Neurology, American Journal of Cardiology* and five other national medical journals.

Dr. Tegeler has lectured throughout the world. He is a diplomat of the National Board of Medical Examiners and a fellow of the Stroke Council of the American Heart Association.

Dr. Rushton is a native of Miami who obtained his M.D. degree from the University of South Florida College of Medicine in Tampa in 1989. He completed his internship and his residency in internal medicine at Vanderbilt University Medical Center.

In 1992, Dr. Rushton returned to the University of South Florida for a fellowship in infectious diseases and tropical medicine. After his

residency in 1994, Dr. Ruston accepted his current post at Marshall University as an assistant professor in the Section of Infectious Diseases. The following year, he also assumed his other role as chief of the Section of Infectious Diseases at Marshall, and in 1997, he received the Outstanding Teaching Award from the residents at Marshall.

Active on the staff of St. Mary's Hospital, Cabell Huntington Hospital, Veterans Affairs Medical Center and Healthsouth Rehabilitation Hospital, Dr. Rushton is currently director of employee health and chairman of the Infection Control Committee at St. Mary's. He has been involved with medical missions to St. Vincent Island and several to Ecuador, and currently serves as co-director of the Chaplin's Assistants Program at St. Mary's.

A diplomate in infectious diseases and internal medicine of the American Board of Internal Medicine, Dr. Ruston is a member of the Christian Medical and Dental Society, the American College of Physicians, Infectious Diseases Society of America and the WVSMA.

Dr. Edwards is a native of Georgia who received his M.D. degree from Emory University in 1981. He completed his internship and residency in general surgery at the University of Louisville.

Following his residency, Dr. Edwards completed a fellowship in surgical oncology at M.D. Anderson Hospital in Houston and then returned to the University to the Louisville as an assistant professor of surgery. Since 1995, Dr. Edwards has been an associate professor of surgery at the University of Louisville, and he also is presently an associate professor in the Department of Physiology and Biophysics and in the Center of Excellence in Applied Microcirculatory Research.

In addition to the University of Louisville Hospital, Dr. Edwards holds appointments at Veterans Administration Hospital, Norton Hospital, Alliant Medical Pavillion, Jewish Hospital and Kosair Children's Hospital. A fellow of the American College of Surgeons, Dr. Edwards is a member of numerous medical organizations. He is the founder and director of the National Registry of Image-Guided Breast Biopsy and is chairman of the Cancer Committee for the University of Louisville.

A noted cancer researcher, Dr. Edwards has received two awards from the University of Louisville for his work. He currently serves on the editorial boards for *Oncology Reports* and *Annals of Surgical Oncology* and is a peer reviewer for six national medical journals.

Dr. Carter received his M.D. degree from the University of Virginia in 1963. He interned and did a residency at Bellevue Hospital in New York City, then served in the U.S. Air Force for two years.

Following his military service, Dr. Carter completed a fellowship in cardiology at Duke University and joined the faculty as an instructor in cardiology. Since 1970, Dr. Carter has been in private practice in Charleston and has been affiliated with Charleston Area Medical Center.

A fellow of the American College of Cardiology and the Council of Clinical Cardiology, Dr. Carter served as governor of the WV Chapter of the American College of Cardiology from 1988-90 and is a past president of the West Virginia Heart Association. He is a clinical professor of medicine at WVU.

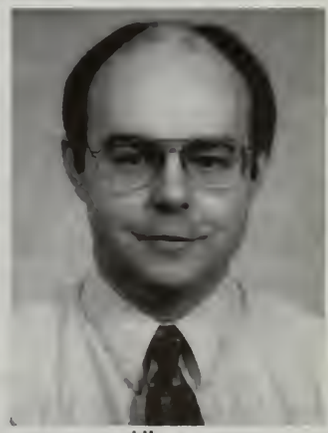
Third Session at Mid-Winter Clinical Conference to focus on topics relating to end-of-life care

This year's WVSMA Mid-Winter Clinical Conference, which will take place at the Embassy Suites in Charleston from January 20-23, will feature a session devoted to issues pertaining to end-of-life care. This Third Scientific Session is set for Saturday, Jan. 22 at 1:30 p.m.

Alvin H. Moss, M.D., director of the Center for Health Ethics and Law at West Virginia University in Morgantown, will moderate this CME event and he plans to start the program with a case presentation entitled *"I Feel Like a New Person."* Following Dr. Moss' presentation, **Sue C. Warren, M.D., F.A.C.P.**, medical director for Kanawha Hospice Care, will lecture on the subject of *"Treating the Patient in the Final Hours."*

Moss

Warren


Hines

Next, **Stephen C. Hines, Ph.D.**, an assistant professor of communication and director of research for the Center for Health Ethics and Law at WVU, will discuss *"Communicating Bad News to Patients and Families."* Dr. Moss will then speak on *"The Ethics and Law of Pain Management,"* and the session will conclude with a case discussion and question and answer session.

Brief profiles of the three speakers for this session begin below. A registration form and a preliminary program for the WVSMA's Mid-Winter Clinical Conference are published in this issue on pages 251-253.

For more details or to register by phone, please call the WVSMA office at (304) 925-0342. To contact the Embassy Suites for room reservations, dial 1-800-EMBASSY or 347-8700.

Speakers profiled

Dr. Moss is a practicing internist and nephrologist who developed an interest in medical ethics as a result of his work in renal dialysis and transplantation. He is currently director of the Center for Health Ethics and Law at West Virginia University in Morgantown, where he is also a professor of community medicine and director of the Bioethics Program.

Dr. Moss has been a participant in the National Leadership Training Program for Physicians in Clinical Medical Ethics at the University of Chicago supported by the Pew Charitable Trusts and the Henry J. Kaiser Family Foundation. He serves as chairman of the Hospital Ethics Committee at WVU Hospitals and is the executive director of the WV Network of Ethics Committees.

A member of the Guardianship Task Force of the WV Department of Health and Human Resources, Dr. Moss chaired the committee that drafted the Health Care Surrogate Act of 1993 and the Do Not Resusitate Act. Dr. Moss is active in a number of other state and national medical organizations and endeavors, and currently serves as a consultant to the Robert Wood Johnson Foundation's program on Promoting Excellence in End-of-Life care.

Dr. Moss' research interests include the use of life-sustaining treatment, advance care planning, and narrative ethics. He has published 75 journal articles and books chapters, as well as presented or published over 64 abstracts. A member of the editorial board for *Advances in Renal Replacement Therapy,* Dr. Moss is a reviewer for *JAMA, American Journal of Kidney Diseases, Journal of the American Society of Nephrology, Journal of Clinical Ethics* and the *Journal of General Internal Medicine.*

Dr. Hines received a B.A. degree in public speaking from Bob Jones University in 1984 and then attended Central Baptist Theological Seminary, where he received Th.M. and M. Div. degrees.

In 1988, Dr. Hines joined the faculty at Purdue University where he taught in the Communications Dept. for four years, and then served as a statistical software consultant while completing work on his doctoral degree. In 1993, he moved to West Virginia to begin teaching at West Virginia University and he also earned his Ph.D. from Purdue.

An assistant professor in the Communications Dept. at WVU, Dr. Hines is also an adjunct assistant professor of medicine and nursing. In this role, Dr. Hines' is responsible for serving as director of research for the Center of Health Ethics and Law and to collaborate with School of Medicine and Nursing faculty on funded research projects.

Dr. Hines is co-chair of the Pre-survey and Needs Assessment Task Force for the Robert Wood Johnson Foundation's West Virginia Initiative to Improve End-of Life Care. He is also serving on the task force responsible for developing criteria for assessing the quality of end-of-life care in West Virginia as part of Healthy People 2010.

A member of the editorial board for the *Journal of Communication,* Dr. Hines is a member of the International Communication Association, the National Communication Association and the Eastern Communication Association.

Dr. Warren received her medical degree at Case Western Reserve University in Cleveland in 1971. She interned at Cleveland Metropolitan General Hospital, and did her residency at North Carolina Memorial Hospital in Chapel Hill, N.C.

After her residency, Dr. Warren moved to Charleston in 1974 and became director of ambulatory medicine at CAMC. Three years later, she joined the faculty of Family Residency Program at the Charleston Division of WVU.

From 1979-1998, Dr. Warren practiced medical oncology and palliative medicine in Charleston before accepting her current position as medical director of Kanawha Hospice Care. In addition, Dr. Warren is presently a clinical professor at the Charleston Division of WVU.

Certified by the American Board of Palliative and Hospice Medicine, Dr. Warren serves as Palliative Care Systems of the task force chair of the Palliative Care Systems West Virginia Initiative to Improve End-of-Life Care. She was a participant earlier this year in the AMA sponsored program Education for Physicians in End-of-Life Care.

Malpractice awards . . . A call to action?

Medical Assurance, the WVSMA's endorsed professional liability carrier, continues to be concerned with the severity of medical malpractice awards throughout West Virginia. This year, juries have awarded almost $15 million for plaintiffs in such cases.

Unfortunately, this trend shows no sign of slowing in West Virginia. If physicians want a fair day in court, they should practice good medicine, defensively, and address the "lawsuit lottery" mentality of the current medical malpractice litigation environment.

Medical Assurance remains convinced that unprejudiced juries and judges return just verdicts when they understand the realities of today's medical environment. This understanding can only be provided through an enthusiastic and energetic defense based on truth, and the committed cooperation of the defense team – the physician, the professional liability carrier and the defense counsel.

For more information concerning Medical Assurance and its defense strategy, call (304) 346-8228 or (800) 331-6298.

SAVE Today

Governor Cecil Underwood and WVSMA Alliance President Rose Romero proudly hold the proclamation which he signed to declare October 13 as SAVE Today in West Virginia. SAVE stands for Stop America's Violence Everywhere and the WVSMA Alliance is focusing its attention on saving schools from violence through a number of projects. Also pictured at the signing are WVSMA Executive Director Evan Jenkins; Terry Rojas, SAVE chairman for the WVSMA Alliance; and Betty Kuppusami, president-elect of the WVSMAA.

Glover named to Nominating Committee for USPC's 2000 Quinquennial Meeting

Douglas D. Glover, M.D., R.Ph., a professor of obstetrics and gynecology at the WVU School of Medicine and an associate professor of clinical pharmacy for the WVU School of Pharmacy, has been selected by the Executive Committee of Revision to serve on the Nominating Committee of the United States Pharmacopeial Convention for its 2000 Quinquennial Meeting. This meeting will be held April 12-16, 2000 in Washington, D.C.

Most countries have a branch of central government that develops the standards by which pharmaceuticals are manufactured. The United States is the only nation where standards for the manufacturing of pharmaceuticals are established by a corporation independent of the government, the USPC, which was created by the U.S. Senate and incorporated in 1820. The FDA enforces the standards once they have been published and finalized by the USPC.

Convention members are elected by their peers who consider them experts in their respective fields. The USPC elects its members every five years. Nominations for these positions are made by schools of medicine and pharmacy, state medical and pharmacy associations, the FDA and the pharmaceutical industry. The Canadian Health Protection Branch has a representative to the convention.

As a member of the Nominating Committee, Dr. Glover is responsible for selecting the two most qualified nominees for each of the 58 positions in preparation for the election at the meeting. It is anticipated that over 500 individuals will be nominated.

Nugent honored at Neurosurgical Society Meeting

Nugent

Kaufman

The West Virginia State Neurosurgical Society Annual Meeting was conducted at the Embassy Suites in Charleston on August 14. Dr. Constantino Amores was the local host for the meeting and Dr. Christopher Marquart, president of the WV State Neurosurgical Society, presided over the meeting.

Dr. G. Robert Nugent, who served as chairman of the Dept. of Neurosurgery at WVU from 1970-85 and is now interim chairman, was the honored guest for the event. He received a distinguished service award and discussed his experiences with sports-related head and spinal cord injuries and reviewed current management of trigeminal neuralgia.

Also recognized with a distinguished service award was Dr. Howard Kaufman, a professor of neurosurgery at WVU. Other presenters included Dr. John France, Dr. Sherry Apple, Dr. Vikram Prabhu and Dr. Frederick Armbrust. Research presentations were made by Darien Kavasmanek, M.D.; Vincent Miele, MSIII; and Vikram Prabhu, M.D.

Williamsburg, Snowshoe sites for ACC meetings

The American College of Cardiology will present the *"The 19th Cardiovascular Conference at Snowshoe"* from Jan. 31 - Feb. 2, and will conduct *"The 27th Annual Williamsburg Conference on Heart Disease"* from Dec. 5-8.

For more details, phone the ACC at (800) 253-4636, ext. 695.

CME & Special Events

Camcare Health Education & Research Institute

"13th Annual Trauma Conference"
Nov. 11, 5 p.m., Robert C. Byrd HSC of WVU, Charleston Division

"Transition Back to Work After Lower Back Pain Injury"
Nov. 12, noon, Marsha Bailey, M.D., Logan General Hospital, Logan

"Community Acquired Pneumonia"
Nov. 16, 6:30 p.m., Juan D'Brot, M.D., Roane General Hospital, Spencer

"Acute Abdominal Pain"
Nov. 17, 6 p.m., Stacey Copeland, M.D., Man Appalachian Regional Hospital, Man

"Management of Cancer of the Oropharynx"
Nov. 22, noon, Austin Wallace, M.D., Robert C. Byrd HSC of WVU, Charleston Division

"Thyroid Cancer: New Developments"
Dec. 6, noon, Steven Artz, M.D., Robert C. Byrd HSC of WVU, Charleston Division

"19th Cardiovascular Conference at Snowshoe"
Jan. 31- Feb. 2, Mountain Lodge Conference Center, Snowshoe

Huntington Medical Community Foundation

"Women's Health Symposium:

"Thyroid Disease in Women"
Nov. 12, 7:20 p.m., Linda Savory, M.D.
"Diabetes and Women"
Nov. 12, 8:10 p.m., Linda Savory, M.D.
(Lectures at Jenny Wiley State Park)

"Sleep Solutions for the New Millennium"
Nov. 18, 7:30 p.m., William R. Beam, M.D., and Debra Stultz, M.D., Lawrence County Medical Society, River Valley Health Systems

"Advanced Course for Improving Your Organization's Performance"
Nov. 19, 8:30 a.m. - 4:30 p.m., Judy Homa-Lowry, R.N., M.S., C.P.H.Q., consultant - Joint Commission Worldwide Consulting, MU Medical Center, Harless Auditorium

"Sleep Disorders Causing Daytime Somnolence"
Nov. 30, 6:30 p.m., Imran T. Khawaja, M.D., Tri-County Medical Society, Paul B. Hall Regional Medical Center Campus, Physician Annex Bldg.

Robert C. Byrd HSC - Morgantown

"16th Annual WVU Hypnosis Training Workshop - The Art in the Science of Healing"
Nov. 12-14, Carruth Center for Counseling and Psychological Services, Robert C. Byrd HSC, Morgantown

"Thyroid Disease Update"
Nov. 19, Robert Hoeldtke, M.D., Ph.D., Garrett Co. Memorial Hospital, Oakland, Md.

"Fall Prevention"
Nov. 23, Shirley Kimble, C-EMT, Minnie Hamilton Health Care Center, Grantsville

"Taking the Hurt Out of Pain, Part 2"
Dec. 9, Charles Ponte, PharmD, Broaddus Hospital, Philippi

"Depression"
Dec. 9, Paul Clausell, M.D., Wetzel County Hospital, New Martinsville

"Pediatric Infectious Disease Update"
Dec. 17, Martin Weisse, M.D., Garrett Co. Memorial Hospital, Oakland, Md.

"Preparatory Course for Urology Certifying Exam: Part II (Mock Boards)"
Jan. 20-22, WVU Dept. of Urology, Embassy Suites, Pittsburgh

West Virginia State Medical Association

"WVSMA 2000 Mid-Winter Seminars & Scientific Conferences"
Jan. 20-23, Embassy Suites, Charleston

Poetry Corner

Balloon Fare

Aloft on jostled air,
steady they stream by,
above a speckled earth.

Balloons, bright colored,
game for lively crews,
going, gone —

catch as catch can.

John Henry McWhorter, M.D.

Lumps

Coal black lumps,
sweat-smudged
acrid, choke.

Hard-bitten
breath ends,
sulphured.

Stript, dead weight now.

John Henry McWhorter, M.D.

WV Public Health Transitions: Strengthening the Public Health System into the 21st Century

The First Annual John Cooper Public Health Transitions Award was presented to Earl Burgess, administrator of the Mid Ohio Valley Health Dept., and Irma Lovejoy, a retired nurse from the Lincoln County Health Dept., for their outstanding contributions to the WV Public Health Transitions Project.

Throughout the past 100 years, developments in public health have led to both improved living conditions and an improved health status throughout the world. Public health programs have continued through the dedicated efforts of public health professionals despite the lack of attention and resources. It was not until the release of the 1988 Institute of Medicine report, *The Future of Public Health,* that current difficulties in the field of public health were brought to light and the need for improving public health systems throughout the nation were made clear.

This report defined the mission of public health as "fulfilling society's interest in assuring conditions in which people can be healthy." For the past 18 months, the West Virginia Legislature and state and local public health representatives have invested money, manpower and time to fulfill this mission. This endeavor, know as the *West Virginia Public Health Transitions Project* is dedicated to transforming and strengthening state and local capacity to protect, promote and improve the health of all West Virginians into the 21st Century.

Recognizing the need for a comprehensive, coordinated and efficient health care delivery system, West Virginia began working collaboratively with state and local public health representatives to redefine basic public health services. The following four basic public health services were identified as necessary to protect the health of West Virginians: Community Health Promotion, Communicable Disease Prevention and Control, Environmental Health Protection, and Administrative Services. Basic public health services are population based and are offered through local health departments to every citizen.

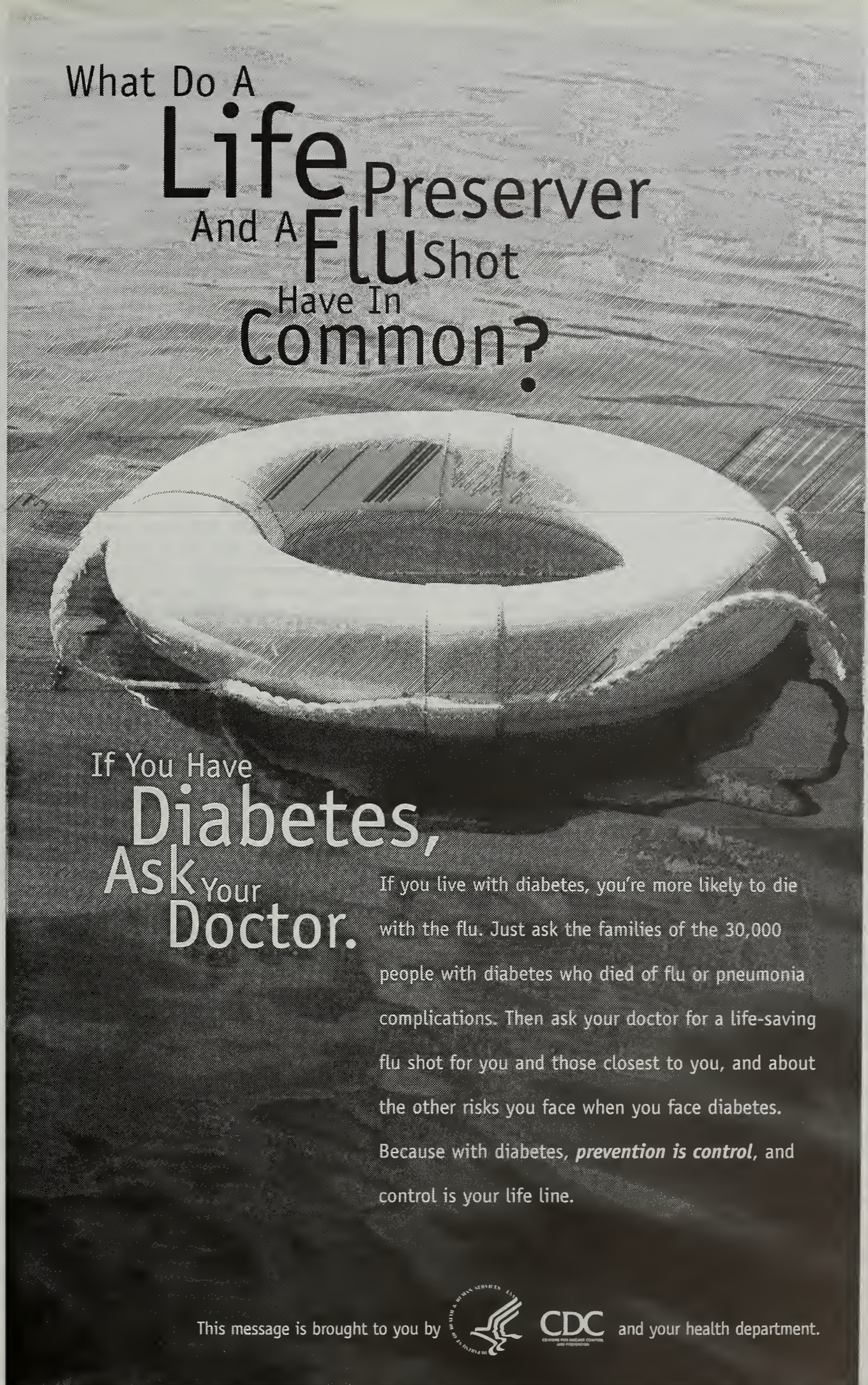
Each local health department is required to submit to the Division of Public Health Nursing and Administration, an annual program plan that includes 138 performance based standards from the four basic public health services. Through the review of these program plans, local and state representatives are able to identify the capacity of each local health department to provide services. This review process assists in identifying the areas in which local health departments are in need of technical assistance and training. The *West Virginia Public Health Transitions Project* designates funds to be used for the purpose of technical assistance in the areas identified.

This project provides the tools necessary to position local health departments as the health intelligence centers of their respective communities, encourage strong and meaningful participation in solving community health problems, and to provide a more professional, accountable and modern public health workforce. The *West Virginia Public Health Transitions Project* is dedicated to producing a coordinated health care delivery system that provides the best environment for "*Healthy People in Healthy Communities.*"

To learn more about the local health department in your community, please visit: www.wvdhhr.org. Click onto Public Health then click onto WV Local Sites. You may then select the county you wish to view.

For more information about the West Virginia Public Health Transitions Project, please contact:

Office of Community and Rural Health Services
Amy Atkins, Coordinator
West Virginia Public Health Transitions Project
1411 Virginia Street, East
Charleston, WV 25301-3013
amyatkins@wvdhhr.org
(304) 558-3210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If you live with diabetes, you're more likely to die with the flu. Just ask the families of the 30,000 people with diabetes who died of flu or pneumonia complications. Then ask your doctor for a life-saving flu shot for you and those closest to you, and about the other risks you face when you face diabetes. Because with diabetes, ***prevention is control***, and control is your life line.
This message is brought to you by CDC and your health department.

Robert C. Byrd Health Sciences Center of West Virginia University News

New medical faculty listed

The following individuals are the new faculty members at the Robert C. Byrd Health Sciences Center:

Morgantown Campus

Anatomy

Kathryn C. Gullion, PhD, research associate, neuroscience; **James T. Porter, PhD**, research associate, pharmacology; **ZhongXin Wu, MD**, research associate, medicine.

Anesthesiology

Christopher M. Grande, MD, prof., trauma anesthesia, critical care.

Behavioral Medicine and Psychiatry

Walter Byrd, MD, associate prof., psychiatry; **Ryan Finkenbine, MD**, asst. prof., forensic psychiatry; **Holly Griffin, PharmD**, asst. prof., pharmacology; **Janie Howsare, MSW**, instructor, social work; **Robert Rogan, DO**, asst. prof., Sharpe Hospital, psychiatry.

Biochemistry

Michael Gunther, PhD, asst. prof.; superoxide dismutase in ALS.

Community Medicine

Chris Martin, MD, associate residency director, occupational medicine; **Robert Pack, PhD**, asst. prof., health education and promotion.

Family Medicine

Peter G. Teichman, MD, adjunct asst. prof., family practice; **Vettivelu Maheswaran, MD**, adjunct asst. prof., obstetrics and gynecology.

Human Performance and Applied Exercise Science

Diana Middleton, OTL/R, asst. prof., occupational therapy.

Medicine

Karen Clark, MD, associate prof., general internal medicine; **Thomas Dickie, MD**, asst. prof., dermatology; **Conard F. Failinger, MD**, associate prof., cardiology; **John E. Parker, MD**, prof., pulmonology; **Muzaffar H. Qazilbash, MD**, (arriving Jan. 2000) asst. prof., blood and marrow transplantation; **Cassandra Salgado, MD**, instructor/chief resident, internal medicine.

Neurology

Gauri V. Pawar, MD, asst. prof., neurophysiology.

Obstetrics and Gynecology

Betsy A. Hutchison, CNM, MSN, instructor, adolescent care.

Ophthalmology

Lee A. Wiley, MD, asst. prof., cornea, external disease, refractive surgery.

Otolaryngology

J. David Garnett, MD, asst. prof., laryngology, voice and swallowing disorders; **Christopher Rassekh, MD**, associate prof., head and neck oncology.

Pathology

Scott Garrett, PhD, research asst. prof., molecular genetic toxicology.

Pediatrics

James J. Burns, MD, associate prof., adolescent medicine; **Sara Cuthill, MD**, asst. prof., hospitalist; **Kimberly Ghuman, MD**, asst. prof., general pediatrics; **Thomas Lamkin, MD**, asst. prof., hematology/oncology; **Xiaoming Li, PhD**, prof., biostatistics; **Charles J. Mullett, MD**, asst. prof., intensive care; **Bonita F. Stanton, MD**, prof. and chair, infectious diseases; **Danielle Tran, MD**, asst. prof., general pediatrics.

Radiology

Abdulkader Al-Azzaz, MD, asst. prof., neuroradiology; **Vickie Williams, MD**, asst. prof., neuroradiology, interventional radiology; **Maurice Miller, MD**, one-year faculty position, general radiology.

Surgery

Jack Bergstein, MD, prof., critical care; **Emilia Dauway, MD**, asst. prof., oncology surgery; **Christian Schunn, MD**, asst. prof., vascular surgery.

Charleston Division

Family Medicine

M. Denise Priddy, MD, asst. prof., family practice; **W. Michael Johnson, MD**, asst. prof., primary care.

Medicine

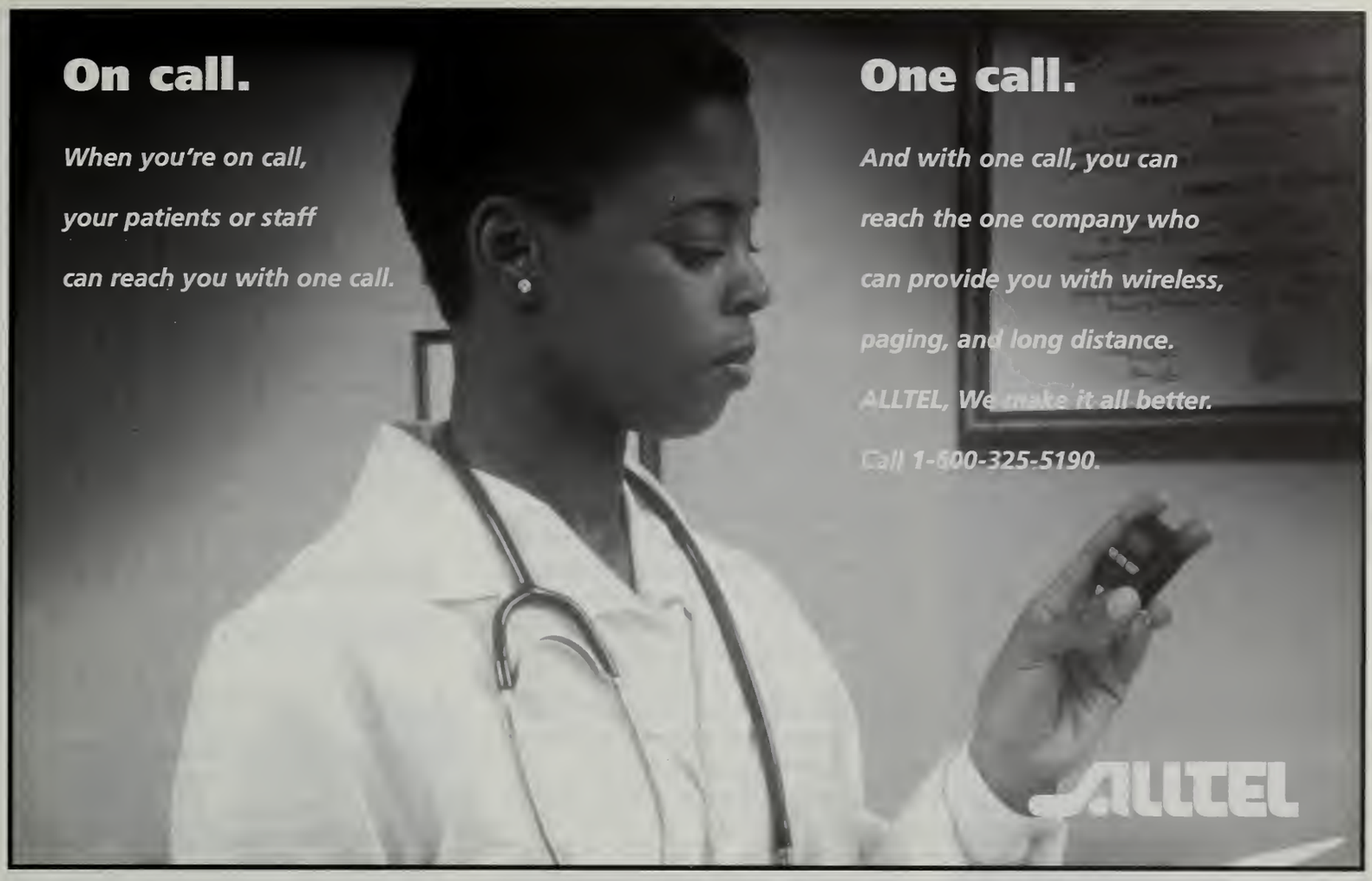
Lynn W. Kitchen, MD, prof., infectious diseases; **Amer Malas, MD**, asst. prof., internal medicine; **Shelda A. Martin, MD**, asst. prof., internal medicine; **Joseph M. Fuscaldo, MD**, asst. prof., internal medicine, pediatrics.

Pediatrics

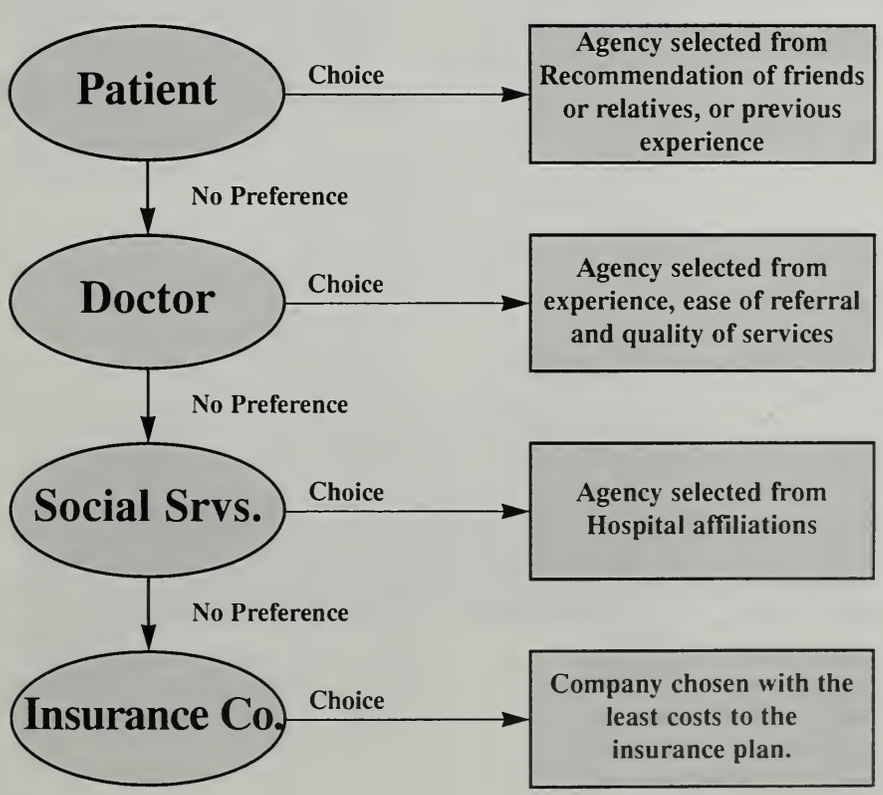
Ashok B. Raj, MD, asst. prof., hematology/oncology.

Obstetrics and Gynecology

William Neel Burns, MD, asst. prof., reproductive endocrinology, infertility.



Healthcare — Who's Choice is it?



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Marshall University School of Medicine News

Fifteen counties represented in new class

Carrie Lockhart of New Haven is invested with the white coat of her chosen profession during the White Coat Ceremony that welcomes new students to the Marshall University School of Medicine. The ceremony is designed to remind incoming students of the human and ethical values central to the practice of medicine.

Fifteen West Virginia counties from Brooke to Jefferson to Raleigh are represented in the entering class of MU's School of Medicine.

Half of the students in this year's class are women, which is a first for Marshall, according to Cynthia Warren, director of admissions. Students range in age from 21 to 42, with the average being 24.7 years. Undergraduate and graduate majors range from traditional premedical and allied health fields to forensic science and chemical engineering.

"This is a diverse class," said Warren. "We have a number of non-traditional students, who historically have done beautifully. They have been out in the real world; they know what they want and they've worked hard and sacrificed a great deal to get here.

Rural Health Center director appointed

Jennifer Plymale has been named director of Marshall's Robert C. Byrd Center for Rural Health, Dean Dr. Charles H. McKown, Jr., has announced.

Plymale previously served as commissioner of West Virginia's Bureau for Children and Families, was an administrator in the Dept. of Health and Human Resources, and handled special projects for Governor Cecil Underwood. She formerly was an administrator at River Park Hospital in Huntington.

"Ms. Plymale has a real feel for rural West Virginia, and already is generating some exciting new ideas for ways we can use the Center for Rural Health as a vehicle to meet the needs of providers and patients in rural areas," Dr. McKown said.

"It's very exciting to have the opportunity to continue outstanding rural health programs begun by Dr. Bob Walker and others at Marshall," Plymale said. "I look forward to working with people throughout the state to find ways to support our rural health system."

Associate, assistant deans named

Dean Dr. Charles McKown has announced the appointment of an associate and an assistant dean for the MU School of Medicine.

Dr. J.D. Harrah, who recently retired from active clinical practice, will become the school's associate dean for curriculum development. He will remain professor and chair emeritus of the Department of Cardiovascular Services.

David N. Bailey, director of continuing medical education, has been promoted to assistant dean.

Hospital renamed to honor Dr. Bateman

Governor Cecil Underwood has changed the name of Huntington State Hospital to the Mildred Mitchell-Bateman Hospital.

Dr. Bateman, formerly chair of Marshall's Department of Psychiatry, plans to retire as the hospital's clinical director later this year.

In addition to serving more than two decades on the Marshall faculty, she formerly was a staff physician at Lakin State Hospital and was director of the West Virginia Department of Mental Health.

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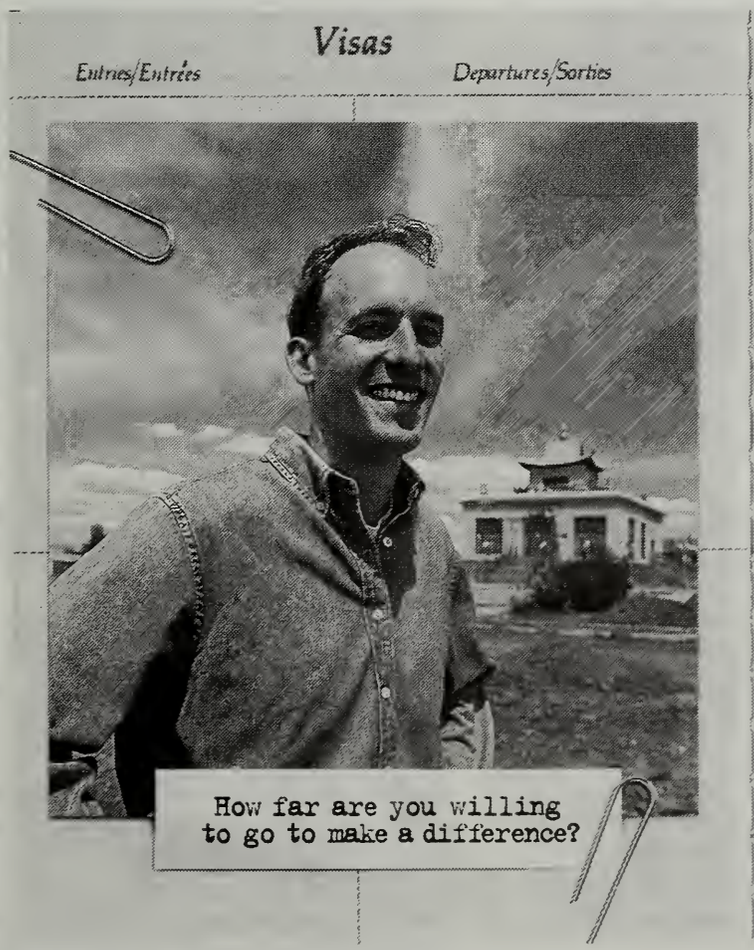

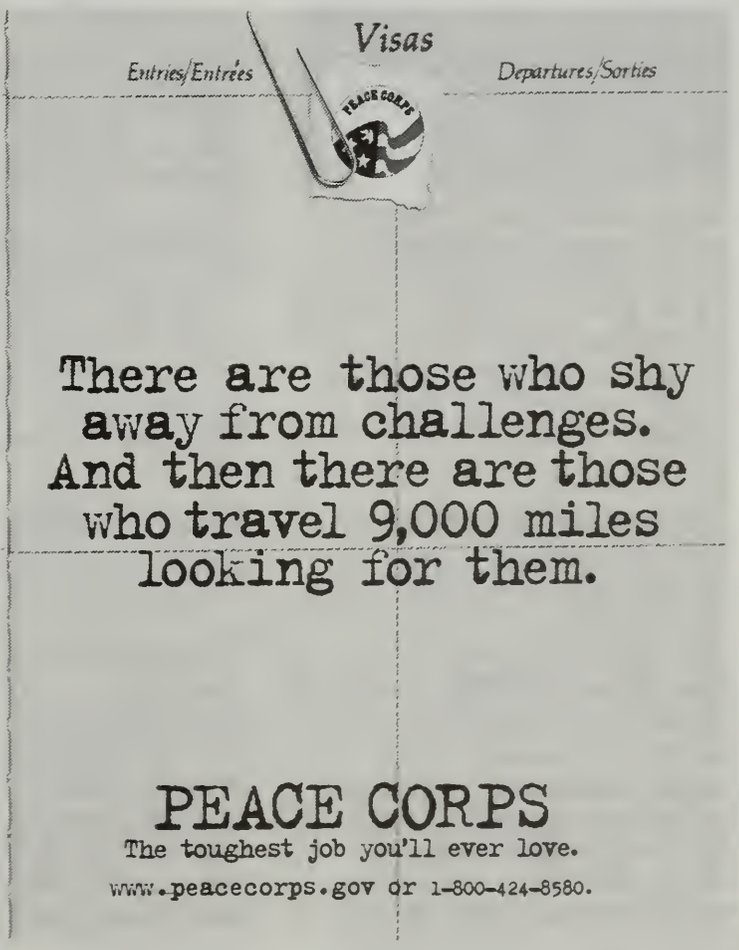

West Virginia School of Osteopathic Medicine News

Future physicians receive white coats

David Nicholas, D.O., a 1993 graduate of WVSOM, delivers the keynote address at WVSOM's Convocation and White Coat Ceremony.

"The healing of others is indeed a privilege and an awesome responsibility. I want to remind you that the white coat that will soon be placed on you is more than a mere lab coat; it is a cloak of caring, compassion and service."

These dramatic words were spoken by David Nicholas, D.O., a 1993 graduate of WVSOM who is a family practice physician in private practice in Barboursville, when he presented this year's keynote address at WVSOM's Convocation and White Coat Ceremony at Carnegie Hall in Lewisburg. Dr. Also addressing the crowd were Olen Jones, Ph.D., president of WVSOM, and St. Albans native Amy Casto, a second-year student who serves as president of the Student Government Association.

The Convocation and White Coat Ceremony signifies the official start of a student's osteopathic education and progress toward a career as a physician.

New library/skills lab/ bookstore dedicated

The WVSOM dedicated its new Library/Osteopathic Skills Lab/ Bookstore in a ceremony on the school campus on Sept. 9.

Work on the $2 million project began in May 1998, and the school moved into the structure this summer after the Greenbrier Commmunity College Center relocated to its new location in Lewisburg. The newly renovated facility includes a high-tech library, a campus bookstore, a new osteopathic skills lab, a classroom, a 12-station computer lab, four audio-visual rooms, and additional student study space. A new arched breezeway was also constructed to attach the free-standing facility to the main WVSOM school building.

The keynote speaker at the ceremony was Senator Oshel Craigo, who is chairman of the Senate Finance Committee.

"This school and its graduates are on the right track," Craigo said. "Osteopathic physicians – including my own personal doctor – are providing care in every county of this state. The statistics reflect the long-standing commitment that this institution has to higher education, and the tremendous contribution it has made to the health care of West Virginians.

Dr. Jones appointed to AOA accrediting body

Olen E. Jones, Jr., Ph.D., president of the WVSOM, has been appointed to the Bureau of Professional Education of the American Osteopathic Association.

The Bureau, a representative body of both the osteopathic profession and the public, serves as the accrediting agency for all colleges of osteopathic medicine.

Broudy elected chair of state advisory council

Ellen Broudy, an academic laboratory instructor assistant, has been elected chair of the University of West Virginia System Board of Trustees Advisory Council of Classified Employees for 1999-2000.

In this role, Broudy will represent the classified staff employees of the state's public colleges and universities.

Thatcher joins faculty

Jack Thatcher, Ph.D., is WVSOM's new assistant professor of developmental biology.

Before joining the WVSOM faculty, Dr. Thatcher lived in Chicago, where he performed research as a postdoctoral fellow at the University of Illinois. He received his bachelor's degree from Oregon State University, his master's degree from Cleveland State University, and his doctorate degree from WVU.

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AMERICAN ACADEMY OF DERMATOLOGY

SAVE our schools from violence

It is such a pleasure to drive the highways of West Virginia in October. The changing color of the leaves catches anyone's attention. And, when you drive around the school districts in 10 counties with active medical alliances, what a sight to see billboard signs that boldly display our health concern – *"SAVE Schools From Violence."*

These billboards are a part of our community awareness campaign to raise consciousness about violence in our schools and they will be displayed at various times throughout the year in areas with participating medical alliances. I am pleased that Governor Underwood proclaimed October 13 as SAVE Today in West Virginia and proud that so many of our alliances celebrated this day with special events. The SAVE proclamation and the WVSMAA's health projects were published in many local newspapers, and the SAVE advertisement provided by the AMA Alliance appeared in *USA Today.*

Alliance members in Raleigh County and Harrison County have been visiting schools, teaching the *"Kindness is Contagious"* program to students. They have been distributing the *"Hands Are Not For Hitting"* activity books and placemats, and the *"I Can Choose"* books that teach self-esteem building and conflict resolution. Other county alliances are developing similar programs.

Parents and teachers are very much a part of the WVSMA Alliance's SAVE Program. *"Bullies and Victims"* pamphlets, which outline steps for intervention and prevention, are being distributed to PTA/PTO groups. In addition, we recently presented sessions on *"Bullies and Victims"* and *"Violence in Teen Dating"* at our Fall Board Meeting to help our members become effective teachers. We must do everything in our power to prevent tragedies like the one in Littleton, Colo., from happening again.

At the AMAA Leadership Confluence held recently in Chicago, Peter D. Blauvelt, who spoke on *"Declaring PEACE on School Campuses,"* repeatedly invited participants to see WVSMAA's exhibit because of our *"Bullies and Victims"* and *"Kindness is Contagious"* displays and programs. This made me very proud to be a part of the West Virginia delegation.

Health awareness is a top priority for the WVSMA Alliance this year. What we do in our communities builds not only awareness of health issues, but also awareness of the Alliance. Hopefully, I will have the pleasure of seeing many new members join us this year.

Rose Romero
President, WVSMA Alliance

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Obituaries

John Edward Echols, M.D.

Dr. John Edward Echols, 89, of Richwood, died Aug. 11 in Summersville Memorial Hospital in Summersville after a short illness.

Dr. Echols was a graduate of Richwood High School, West Virginia University and the University of Maryland Medical School, where he received his M.D. in 1934. He interned at Baltimore City Hospital and completed his residency training at Mountain State Hospital.

Dr. Echols began practicing in 1935 and during his career he delivered 4,300 babies. From 1938-42, Dr. Echols was medical officer of Camp Cranberry. He then served in the U.S. Medical Corp from 1942-45 under General George S. Patton and earned five battle stars.

A member of the WVSMA since 1936, Dr. Echols served on Council and was a past president of the Central West Virginia Medical Society. He was also a member of the AMA and Southern Medical Association. Dr. Echols was a member of First United Methodist Church, Rotary Club and was a Mason and a Shriner.

An active city supporter, Dr. Echols was instrumental in developing Sacred Heart Hospital, Cherry Hill Golf and Country Club, and Richwood City Park.

Survivors include his wife, Barbara Echols; three sons, John E. Echols, Jr., D.D.S. of Lewisburg; William J. Echols, M.D., of Huntington; and Charles R. Echols, a minister in Clarksburg; one stepdaughter, Mary Ann Boggs of Craigsville; seven stepgrandchildren.

Memorial contributions may be made to First United Methodist Church, 2 Walnut St., Richwood, WV 26261.

Shoukry L. Francis, M.D.

Dr. Shoukry L. Francis, 77, of Sullivan Road in Beckley, died July 17, in a Beckley hospital following a short illness.

Dr. Francis was born in Cairo, Egypt. He received his medical training at the Faculty of Medicine in Cairo and served his internship at East Tennessee Baptist Hospital in Knoxville, Tenn. After completing his residency in urology at Charlotte Memorial Hospital in Charlotte, N.C., and St. Joseph's Infirmary in Atlanta, Dr. Francis completed a fellowship in urology at The Royal College of Surgeons in London.

Certified by the American Board of Urology, Dr. Francis was a member of the American Urology Association. He was a member of Faith Baptist Church in Prosperity.

Survivors include his wife of nearly 50 years, Merry Skov Francis; and two brothers and a sister in Egypt.

Gilbert A. Ratcliff, Sr., M.D.

Dr. Gilbert A. Ratcliff, Sr., M.D., 101, of Huntington, died May 6 at his residence.

Dr. Gilbert was born Oct. 7, 1897 in Rossville, Ill., a son of the late Dr. A. Lonzo Ratcliff and Laurena McHenry Ratcliff. He grew up in Kingman, Ind., and was a schoolteacher before graduation from Indiana University. He received his M.D. at Johns Hopkins University and completed his Ob/Gyn residency at the Yale New Haven Hospital.

From 1930 until his retirement in 1978, Dr. Ratcliff practiced in Huntington and delivered over 10,000 babies. He had been a member of the WVSMA since 1930 and was a past president of the Cabell County Medical Society. In addition, Dr. Ratcliff was a member of the American College of Obstetrics and Gynecology, Johnson Memorial United Methodist Church, Huntington Downtown Lions Club, B.P.O. Elks 313, and American Legion Post 16.

Dr. Ratcliff was preceded in death by his wife, Jessie Vaughan Ratcliff, one sister and three brothers. He is survived by two sons and daughters-in-law; Dr. & Mrs. Gilbert A. (Betsy) Ratcliff Jr., and Dr. & Mrs. Bruce A. (Ann) Ratcliff of Huntington; seven grandchildren, Lenore Ratcliff Tweel, Leah Ratcliff Horton, Lynn Ratcliff, Alan Ratcliff, Todd Ratcliff, Jonathan Ratcliff and Barclay Ratcliff Fuss; two great-grandchildren; Elizabeth Ratcliff and Kathryn Tweel; and one brother, Dr. Frank Ratcliff.

Memorial contributions may be made to Johnson Memorial United Methodist Church.

Joseph Edwin Ricketts, M.D.

Joseph Edwin Ricketts, M.D., 86, of Huntington, died at his residence August 7 following a lengthy illness.

Dr. Ricketts was born in Covington, Ky., on Sept. 12, 1912, and he attended Covington public schools and entered the University of Cincinnati at age 16. Upon graduation from the University of Cincinnati, Dr. Ricketts was accepted into the medical school at the university, and he was the youngest in his class.

Dr. Ricketts did his internship and residency at St. Luke's Hospital in Chicago. He began his career as a ship's doctor on a commercial fishing vessel out of Boston. He later practiced in Cape Hatteras, N.C., and Dillonville, Ohio, before settling in Huntington, where he practiced family medicine for 40 years.

Dr. Ricketts was known in the community as a world traveler and avid photographer. He had been a member of the WVSMA since 1946 and was also a

member of the AMA, West Virginia Academy of Family Physicians, Southern Medical Society, the Cabell County Medical Society and the Explorer's Club. In addition, Dr. Ricketts was an Eagle Scout and a member of the First Presbyterian Church.

Surviving Dr. Ricketts are his wife of 50 years, Mary J. Turley Ricketts of Huntington, two sons, Joseph E. Ricketts, Jr., and his wife, Brenda, of Centerville, Ohio, and Jay S. Ricketts and his wife, Lynn, of Atlanta; four grandchildren, Christopher H. Ricketts of Cincinnati; Amanda B. Ricketts of Centerville, Ohio, Benjamin A. and Merrill B. Ricketts of Atlanta.

Memorial may be sent to the Cabell Huntington Hospital Foundation.

Stephen D. Ward, M.D.

Dr. Stephen D. Ward, 75, of Wheeling, who was editor of the *West Virginia Medical Journal* for the last 23 years and was a past president of the WVSMA, died on Oct. 7 at Ohio Valley Medical Center in Wheeling of cancer.

Dr. Ward was a native of Pittsburgh who graduated from Mount Lebanon High School where he was an All State center on the football team. He attended LaSalle Military School in Long Island before joining the U.S. Army in 1943.

Dr. Ward entered the European Theater of Operations as a member of the 17th Airborne Division. During the Battle of the Bulge, he sustained a head wound from an exploding tank round. After brief treatment, he was returned to the front and later awarded the Purple Heart for this action.

Following his military service, Dr. Ward enrolled at the University of Pittsburgh, where he received a B.A. degree in 1950 and his medical degree in 1954. While at the university, he resumed his football career, earning three varsity letters until he sustained a knee injury in a game against Notre Dame which halted his playing career.

After medical school, Dr. Ward remained in Pittsburgh for his internship at Mercy Hospital and his residency at Western Psychiatric Institute. From 1958-61, he practiced psychiatry in Mount Lebanon, Pa., and worked at Mayview State Hospital outside of Pittsburgh.

In 1961, Dr. Ward moved his family to Wheeling so he could join the staff at Wheeling Clinic, where he practiced until his retirement in 1995. During his years at Wheeling Clinic, he served as chairman and was also very active on the staff at Ohio Valley Medical Center where he served as president of the medical staff in 1983, and was chairman of the Department of Neurosciences and medical director of the Psychiatric Department.

Dr. Ward became a member of the WVSMA in 1962 and soon became very active on the Legislative Committee, Council and the WESPAC board of directors. In 1971, he was named an associate editor of the *West Virginia Medical Journal,* and in 1976 he rose to his cherished post as editor. Dr. Walter Vest, who served as editor from 1937-62, was the only other editor with a longer tenure than Dr. Ward's.

His close friend, Dr. John Holloway of Wheeling, stated that one of the many reasons he respected Dr. Ward so much was that "his positions were based on what he saw was best for the organization, not for himself. He was willing to take unpopular stands knowing that he would get knocked down. He was back up the next day with a remarkably positive attitude.

"As demonstrated in his years of meticulously written and hard-hitting editorials for the *Journal,* Dr. Ward was dedicated to preserving the physician/patient autonomy while condemning those out to undermine it. He was intolerant of physicians or those in organized medicine who would give any ground in this area."

In addition to his involvement with the *Journal,* the Legislative Committee, Council and WESPAC, Dr. Ward served as president of the WVSMA from 1970-80, and as an alternate delegate and a delegate to the AMA for many years.

At the national level, Dr. Ward was also very active with the AMA. He served on the AMA's Council on Legislation for 12 years and was the AMA's representative on the Legislative Council of the American Dental Association. Since 1995, Dr. Ward had been on the editorial advisory board for the AMA's publication *Senior Physician News.*

During his career, Dr. Ward also served as president of both the Ohio County Medical Society and the West Virginia District Branch of the American Psychiatric Association. He was a fellow of the American Psychiatric Association, and was a clinical associate professor in the Department of Behavioral Medicine and Psychiatry at WVU.

Dr. Ward was preceded in death by his parents, John J. and Harriet Dailey Ward. Surviving are his wife, Mary Louise Portman Ward; two sons, Dr. Matthew J. Ward and his wife, Yvelette of Bluefield, and John J. Ward, of Wheeling; a daughter, Susan Board and her husband, David, of Moundsville; four brothers, John J. Ward and Anthony J. Ward, both of Pittsburgh; Paul B. Ward of Alpharetta, Ga.; and James A. Ward, of Memphis, Tenn.; two sisters, Mary H. Drane of Pittsburgh; and Patricia Mundy of Mobile, Ala.; four grandchildren, Ingrid, Glynis, Erin and Stephen Board; and numerous nieces and nephews.

Memorial contributions may be made to Mt. de Chantal Visitation Academy, Wheeling, WV 26003.

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West Virginia Medical JOURNAL

Volume 95 No. 6 — West Virginia State Medical Association — November/December 1999

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Seminars

Cancer - "Winning the Game"
Tuesday, Jan. 18, 2000
12:30 p.m. - Seminar
5:30 p.m. - Pre-Game Meal and Entertainment
7:30 p.m. - Marshall vs WVU Basketball Game
Charleston Civic center
Charleston, WV
James N. Frame, MD
Program Chairman

19th Cardiovascular Conference at Snowshoe
Jan. 31 - Feb. 2, 2000
Mountain Lodge Conference Center
Snowshoe, WV
William H. Carter, MD, FACC
Program Chairman

Issues in Medical Ethics Basic Certificate Program
Friday, March 3, 2000
8 a.m. - 4:30 p.m.
Camcare Health Education and Research Institute, Education and Training Center
Mary Lou Lewis, MD
Robert. Hall, PhD
Program Chairmen

27th Annual Newborn Day
Friday, March 24, 2000
8 a.m. - 4:30 p.m.
Robert C. Byrd Health Sciences Center of West Virginia University/ Charleston Division Auditorium
Stefan R. Maxwell, MD
Program Chairman

Obstetrics and Gynecology Update: A Pre-conference for Family Physicians
Thursday, April 6, 2000
5 p.m. - 9 p.m.
Charleston House Holiday Inn
Charleston, WV
E. Reed Heywood, MD
Program Chairman

Pain and Suffering: A Multidimensional Approach
Wednesday, May 17, 2000
7:30 a.m. - 4:15 p.m.
University of Charleston
Charleston, WV
Carolyn Sue Warren, MD
Program Chairwoman

On-Site Continuing Education Outreach Programs

Urticaria
Wednesday, Jan. 5, 2000
12:15 p.m.
Montgomery General Hospital
Montgomery, WV
Nasim A. Sheikh, MD

Pain Management
Wednesday, Jan. 5, 2000
6:00 p.m.
Fayette County Medical Society
Plateau Medical Center
Oak Hill, WV
J. K. Lilly, MD

Back to Work After a Lower Back Injury: A Functional Model
Friday, Jan. 14, 2000
11:45 a.m.
Logan General Hospital
Logan, WV
Marsha Bailey, MD, MPH

Medical Ethics
Wednesday, Jan. 19, 2000
6:00 p.m.
Man ARH
Man, WV
Mary Lou Lewis, MD

Back to Work After a Lower Back Injury: A Functional Model
Wednesday, Jan. 26, 2000
11:45 a.m.
Summers County ARH
Hinton, WV
Marsha Bailey, MD, MPH

Camcare Health Education and Research Institute

West Virginia Medical JOURNAL

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A winter snow scene along a country road in West Virginia.

Photo courtesy of Stephen J. Shaluta, Jr., West Virginia Department of Commerce.

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Manuscript Guidelines

All articles for the *West Virginia Medical Journal* must be submitted on an IBM compatible disk. Microsoft Word 97 is preferred, but other languages are acceptable. If the manuscript contains tables, the main body of the manuscript and references should be saved as one item, i.e., *article*, and then each table should also be saved as a separate item, i.e., *Table 1, Table 2.*

All scientific manuscripts should be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."* Papers will not be considered for publication if they have already been published or are described in a manuscript submitted or accepted for publication elsewhere. All persons designated as authors should have participated enough in the work to take public responsibility for the concept.

Manuscripts should be accompanied by one extra copy, be double-spaced, have each page numbered and should include a title page, an abstract of no more than 150 words, and references numbered consecutively. No more than 10 references will be published and then a statement will appear that the author should be contacted for the other references listed in the manuscript.

Tables, figures and photos should be numbered, and indicated with parentheses whenever they are mentioned in the text, i.e. (Table 1), (Figure 1). Legends should be included for all figures and photographs.

Photos must be unmounted glossy prints in a 5 x 7 format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author at a cost of $13 for each photo. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be created in black and white.

All scientific material is reviewed by the editor and three members of the Publication Committee. Other articles are usually only reviewed by the editor. All articles should be addressed to:

F. Thomas Sporck, M.D., F.A.C.S., Editor
West Virginia Medical Journal
P.O. Box 4106
Charleston, WV 25364

If you have questions or need more information, phone Nancy L. Hill, managing editor at (304) 925-0342.

President's Page

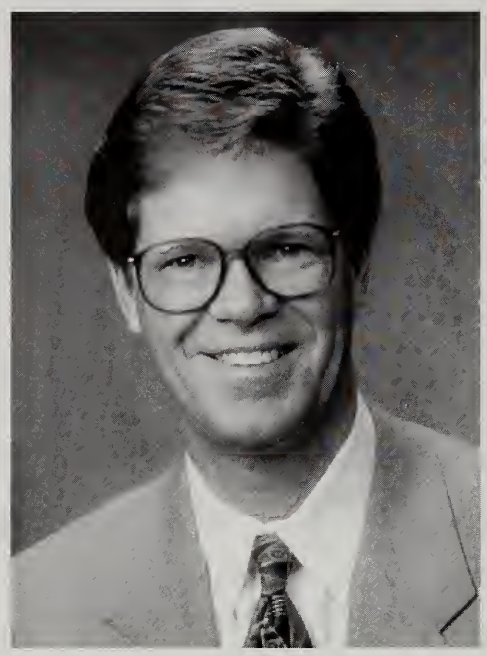
The formula for success

If one wants to succeed in any endeavor, then one must first develop a good game plan. A carefully thought out course of action is crucial to any major undertaking. The objectives must be laid out and then the process for obtaining these objectives needs to be thoroughly studied and understood.

Failure to follow this process invites disaster. Does anyone remember Senate Bill 576? When this was being debated, we were told to go to the Capitol to argue against it. We ended up generating more ill-will than anything else and the bill passed anyway. Our game plan wasn't well thought out to say the least, but we have learned from our mistakes.

The current leadership of the West Virginia State Medical Association has developed an excellent understanding of the legislative process. But, simply understanding the process is not enough. The formula for success is really quite simple: Develop a good game plan and then fund it well.

The trial lawyers, chiropractors and optometrists in West Virginia



obviously know this formula well because they give much more money to their political action committees than WVSMA members do to theirs. It is no wonder that they are able to influence the legislative process to the benefit of their professions.

I am not saying this is right or wrong — it's a simple reality of the way our government works. Physicians must do better and I am confident that you will. I have set the goal for WESPAC contributions for the year 2000 at $150,000. Many of the WVSMA leaders have already contributed at the $1,000 level and I am sure the rest will follow, but we cannot do this alone.

Soon, you will be receiving a mailing from WESPAC. I want every physician to return it with the maximal amount that you can give! Many crucial issues will be decided over the next few years. The future of our profession in West Virginia may very well be at stake.

Just remember the formula for success: Develop a good game plan and then fund it well. If we all follow the formula, we will all enjoy the sweet smell of success.

Phillip R. Stevens, M.D.

Editorial

Provider tax must finally be removed

Earlier this year, WVSMA conducted a membership survey which indicated that the two most important legislative issues our members want addressed are the provider tax and tort reform. I strongly agree and I want to devote my first editorial as editor to the subject of the provider tax.

This onerous regressive tax came into effect in 1992. It was a "voluntary" tax of 23% on Medicaid receipts. The rate was equal to the state match for Medicaid funding. This agreement was entered into because there had not been any increase in Medicaid reimbursement since 1981. A similar plan had been entered into by hospitals in 1990.

This proposal was published in the *Journal* in August 1991 and was discussed and agreed to at the Annual Meeting that year. The West Virginia Legislature passed it into law in the 1992 session. Shortly after this law became effective, the federal government declared such arrangements illegal effective July 1, 1993. They further stated that a provider tax to draw federal matching funds had to be a broad-based tax on all providers.

In response to the federal government's action, the West Virginia Legislature held a Special Session and enacted the current provider tax — a gross receipts tax on physicians as well as other providers (institutions and individuals). For physicians, this is a 2% tax on gross receipts.

Due to the way this tax is structured, it is extraordinarily unfair to solo practitioners with high overhead. The effective tax rate for a 30% overhead is approximately 3% of net income, while for a 70% overhead it is about 7% of net. The state is effectively unfairly punishing rural independent physicians (those it says it needs the most) who usually have higher overheads.

It would seem that society has made the decision that health care is a right that must be extended to all citizens. If this is indeed the case, then the burden of funding the cost of that care must be borne by all of society — not just those who provide the care.

In the May 1993 edition of the *Journal*, Dr. Robert Pulliam, who was president of the WVSMA at the time, suggested the following six alternatives for funding Medicaid:

1. Increase the general sales tax 1%.
2. Increase state income tax rates from 3% to 3.42%, 4% to 4.56%, 5% to 5.7%, and 6.5% to 7.4% to raise a similar amount of funds. Persons earning less than $60,000 would pay less than 80 cents per day to support the Medicaid health system.
3. Reduce the gasoline tax from five cents to two cents per gallon, which is the actual amount needed for new highway construction, and raise the sales tax to 7%.
4. Tax institutional providers as described in the Senate proposal since they are in a win-win situation. Remove the provider tax on individuals, reduce the food tax to zero and raise the general sales tax to 7% or 7.5%.
5. Use "sin taxes," i.e. taxes on alcohol and tobacco to further decrease the rates already mentioned.
6. Consider the previous Caperton proposal of a 1% increase in tax rates above $100,000 to reduce the plans stated in numbers 1 and 2 above.

Another possible alternative to fund the Medicaid match is to place a surtax on all health insurance premiums (including PEIA and Medicare secondary insurance). Today, the state has funds from the tobacco settlement which may provide yet another option. At present, West Virginia taxes only cigarettes. A tax on smokeless tobacco, cigars and pipe tobacco (all tobacco products), could at least partially fund the state's portion of the Medicaid match. Smokeless tobacco is a leading cause of oral cancer, and unfortunately, we have the distinction of having one of the highest rates of utilization of any state in the nation.

Many choices have been offered, but it is up to the WVSMA to offer a proposal to Governor Underwood and the Legislature that is the most feasible for the physicians and the citizens of this state. West Virginia is the only state which currently has such a provider tax and it is time the governor and our legislators finally rid us of this punitive tax.

F. Thomas Sporck, M.D., F.A.C.S.
Editor

Special thanks to Dr. Jarrett

I want to take this opportunity to thank Dr. Joe Jarrett of Oak Hill for all of his many years of service as an associate editor of the *Journal*. Dr. Jarrett recently resigned after serving as an associate editor since January 1973.

Dr. Jarrett's thoughtful comments on manuscripts and articles, as well as his valuable insights into matters affecting the *Journal*, are missed by the members of the Publication Committee. We greatly appreciate his outstanding dedication to the *Journal*.

You are cordially invited to attend our

Legislative Reception

Hosted by

West Virginia State Medical Association

Thursday, January 20, 2000

6:30 p.m. - 8 p.m.

Embassy Suites Hotel

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at the Legislature

Feb. 20 & 21
Charleston, WV

Please join your fellow physicians **Feb. 20 & 21** for a very important organized lobbying day at the Capitol. Come wearing your WHITE COATS to help make an impact in the minds of legislators that physicians are united and ready to advocate for a better health care environment in West Virginia. Don't forget to bring your spouse, office manager or anyone who is concerned about physician/patient issues.

The schedule starts Sunday, Feb. 20 at the Embassy Suites Hotel with detailed lobbying advice by an expert in government relations from the AMA. We will then hear an important issue briefing and be given talking points to prepare us for our trip to the Capitol as a unified voice for physicians and patients.

To register for White Coat Day, please call the WVSMA office at (304) 925-0342 or e-mail Amy Tolliver at Amy@wvsma.com.

Agenda

Sunday, Feb. 20

6:30 p.m. - 9 p.m.	Dinner/Reception with presentation, *"Lobbying the Legislature"*

Monday, Feb. 21

8 a.m. - 10 a.m.	Breakfast and briefing on WVSMA Legislative issues and briefings from key legislative leaders
10 a.m.	Off to the Capitol! Meet with Legislators/Observe Committee Meetings
10:30 a.m - 3 p.m.	Observe House of Delegates and Senate Sessions and meet with Legislators
3 p.m.	Depart

Special Report

WESPAC: A new course for 2000

DOUGLAS E. MCKINNEY, M.D.
WESPAC Chairman

WESPAC 2000 — New directions! New constitution! New levels of participation! New directions in donations!

Many new ideas for WESPAC were brainstormed at the WVSMA's Annual Meeting at The Greenbrier with the help of Tracy Sinnott, our AMPAC representative for WV; the visiting state presidents who attended this year's meeting; WVSMA President Dr. Phillip Stevens; and other WVSMA members. The meeting began with Tracy presenting me with a plaque for WESPAC for achievement in increased donations. She then told us that we should be asking members for larger donations and suggested a $1,000 level for leaders of WESPAC and WVSMA.

Dr. Stevens, Dr. John Holloway, the WVSMA's president-elect, and I have all responded to her challenge and we have written our checks. In addition, Dr. Stevens has set a goal of $150,000 for WESPAC contributions in 2000 *(Please see his message on page 294 on this subject.)*

Is this a lofty goal? No, not really when you stop to consider that if every WVSMA member would contribute $100, our WESPAC treasury would be almost $200,000. We will never achieve the stature and influence we need to really make a dramatic difference until or unless the members begin to ante up.

In addition to increasing the amounts of contributions, major changes have been proposed for WESPAC's constitution. The current constitution allows for too large of a board of directors, and many are not attending meetings or even showing interest. In fact, many component societies have never even named a member to the board. The new constitution will be voted on by the WESPAC board at our next meeting on Friday Jan. 21 at 4:30 p.m. at the Embassy Suites during the WVSMA's Mid-Winter Clinical Conference. The new constitution delineates a board of two members from each congressional district, two from the state at large, and one from the Alliance and the Council. I believe a smaller board of interested, active members will be able to achieve much more for the WVSMA.

Another concensus arrived at during the WESPAC meeting at the Annual Meeting, was that donations to candidates should be at higher levels, but concentrated on key races and key positions. Special efforts will be made in judicial races in those circuits in which doctors have consistently fared poorly. We plan to ally with other concerned organizations such as the WV Chamber of Commerce and others who support restoring balance and fairness in our civil justice system in judicial races.

New events are planned as part of WESPAC's new focus. A lobbying education program is set for Sunday, Feb. 20, in conjunction with this year's White Coat Day on Monday, Feb. 21 at the Legislature. *(Please see the previous page for a schedule of these events.)* We also plan to resume our legislative briefing before the Legislative Reception. This briefing, *"State Capitol Report: Update on the 2000 Legislative Session,"* will take place from 5 p.m. - 6:30 p.m. on Thursday, Jan. 20 during the WVSMA's Mid-Winter Clinical Conference, with the Legislative Reception set for 6:30 p.m. I hope you will mark your calendars today to attend all of these important events.

The crux of the matter is simple. Physicians have too long neglected politics and legislative action. To regain the esteem and respect our profession deserves, physicians must pay, not only with money, but also with their time and effort. How long has it been since you talked to your legislators? Do you even know your legislators?

Amy Tolliver, the WVSMA's government relations specialist, and Nancy Tonkin, the WVSMA's lobbyist, have given us great input in outlining new ideas for WESPAC and they are very excited about our opportunities for change in both the political and legislative arenas. They will be working very hard during the session on the issues that are most important to our members, but we as physicians are the most effective lobbyists for our profession. I ask you to please get to know your legislators, contribute to their campaigns, but also make the maximum contribution you can to WESPAC.

Send your personal check TODAY! WESPAC must be able to reestablish medicine's rightful place in the political and legislative processes in West Virginia.

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Special Article

Continuity of care important with hospitalists

By Medical Assurance

Q. I've been hearing more and more about "hospitalists." What can you tell me about them?

A: The term "hospitalist" was coined three years ago, and refers to a physician who spends more than 25 percent of his/her time treating inpatients. There are about 3,000 hospitalists nationwide, and the "hospitalist movement" is growing, with hospitalists forming a national association and medical schools looking at hospitalist fellowship and residency programs.

Hospitalists usually work full-time in a hospital; they typically make rounds several times a day, and coordinate the patient's care, including the medical professionals involved such as discharge planners, case managers and nurses. They have the benefit of being present when unexpected complications arise and can handle them faster, as well as the fact that they are available for questions from the patient and family.

The other benefits of utilizing hospitalists are shorter stays and lower costs. According to recent studies, hospitalists can cut a patient's length of stay by about 30%, and cut costs by about 20%. However, this has some medical/legal experts worried that HMOs and insurance plans will focus too much on the bottom line.

Communication and continuity of care are also concerns of medical professionals — upon admission to a hospital, the primary physician transfers care of the patient to the hospitalist, who, upon discharge, transfers the patient's care back to the primary physician. That means the primary care physician who has treated this patient for awhile, knows his/her family history, personality, compliance, etc., no longer has control of the patient's care. But not all physicians think that's bad since rapid technological advancements in hospitals have led to increasingly complex inpatient care. In addition, primary care physicians are not as able as hospitalists to develop specialized knowledge of particular conditions which warrant admission. Communication then becomes the key — among the patient, the hospitalist, and the primary care physician. A recent study by the Agency for Health Care Policy and Research of patients who were hospitalized for chest pain revealed those patients whose regular physicians remained involved in their care were less likely to report communication problems regarding tests (20 vs. 31%), health habits (31 vs. 38%) and level of activity after discharge (42 vs. 51%).

Chances are the hospitalist movement is here to stay. The bottom line is still the same: the goal is optimal patient care, and the best tool is good physician-patient relationships.

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Fibula free flap reconstruction of composite oromandibular defects

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Abstract

The surgical treatment of advanced oral cavity cancer presents a difficult reconstructive challenge since tumor resection can result in "through and through" bone and soft tissue defects. Reconstruction is essential for an acceptable aesthetic outcome, as well as functional oromandibular rehabilitation. The advent of microvascular free tissue transfer now allows immediate reconstruction of these large composite resections, and offers significant advantages over more traditional techniques. Success rates approach 90%-95% at most large centers. In this article, we describe the challenging decisions faced by clinicians treating these patients, and discuss our reconstructive method of choice, the fibula osteomyocutaneous free flap.

Introduction

The restoration of oral function following surgical treatment of oral cavity carcinoma remains one of the most significant challenges for the head and neck reconstructive surgeon. Extensive tumors often mandate large composite resections that may include the tongue, palate, floor of mouth, mandible and overlying skin.

These resultant defects require reconstruction of complex osseus, soft tissue and dental anatomy. The challenge lies not only in "filling the hole," but in reestablishing oromandibular function, as well as cosmesis. In prior years, reconstructive efforts have been limited by high rates of implant extrusion, limited bone graft viability, and the lack of resistance to salivary contamination and radiation (1,2). Patients were often left oral cripples (Figure 1), requiring permanent gastrostomy feeding and tracheotomies due to aspiration.

In recent years, the advent of microvascular techniques has made it possible to reconstruct these challenging cases at the time of tumor resection using composite free tissue grafts with much improved aesthetic and functional results (Figure 2). These grafts allow the replacement of all resected components, and have a significant impact on the patients' postoperative functional status. In this way, microvascular free tissue transfer allows the reconstruction of these defects using vascularized soft tissue and bone, which may be molded to the defect, restoring more normal form and function. Current choices in composite free flap reconstruction include the fibula, scapula/latissimus dorsi, iliac crest, and the radial forearm flaps.

Figure 1. **Example of "andy gump" deformity typical after composite resection without free flap reconstruction. Note loss of chin projection.**

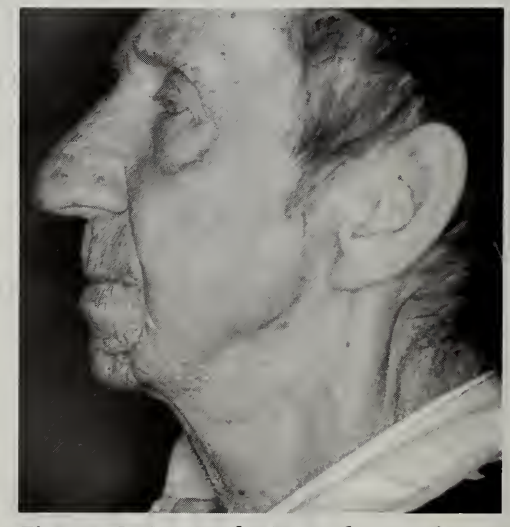

Figure 2. **Lateral view of a patient after fibula free flap. Note good chin projection and maintenance of mandible arch.**

In the past, oral cavity reconstruction has been performed using local flaps, split thickness skin grafts, and pedicled myocutaneous flaps, but these are not ideal when a segment of mandible is removed with the tumor. Bony reconstruction is essential for a good functional outcome, especially with anterior mandible defects (2).

Postoperative disability can be predicted by the preoperative status of the oral cavity and dentition, the extent of mandible resected, the site of the tumor, and volume of the soft tissue defect (3). Those patients determined to be at highest risk for disabilities are ideal candidates for free flap reconstruction. The alternatives to free flap reconstruction include metallic plate and alloplastic reconstruction, non-vascularized bone grafts (autograft and homograft), and pedicled osteomyocutaneous flaps (e.g., pectoralis major with rib). The limitations of these techniques lie in their high extrusion rates, lack of bone viability, limited amount of available bone stock, and the high sensitivity to salivary contamination and postoperative radiation (4).

For these reasons, we feel that composite free tissue transfer is the reconstruction of choice in this group of patients. The ideal composite free flap should provide a sufficient stock of bone to reconstruct the mandible from angle to angle, provide a large area of reliable, pliable skin, have a long vascular pedicle, have relative ease of harvest, and result in minimal donor site morbidity (1,3). The graft which best meets these requirements, in our experience, is the fibula free flap system.

The fibula free flap consists of a vascular pedicle based on the peroneal artery, the fibula bone and associated skin and/or muscle (5). The skin overlying the fibula has a blood and nervous supply that enables reconstruction with sensate potential (6). Arterial and venous perforators to the skin paddle, through the soleus muscle, may be either fasciocutaneous or musculocutaneous. Therefore, inclusion of a cuff of soleus ensures an adequate cutaneous blood supply. The fibula supplies up to 25 cm of straight rigid cortical bone, which is the greatest length of bone available of all the osseus free flaps (Figure 3). In addition, up to a 16 x 12 cm skin paddle may be harvested as well (Figure 4).

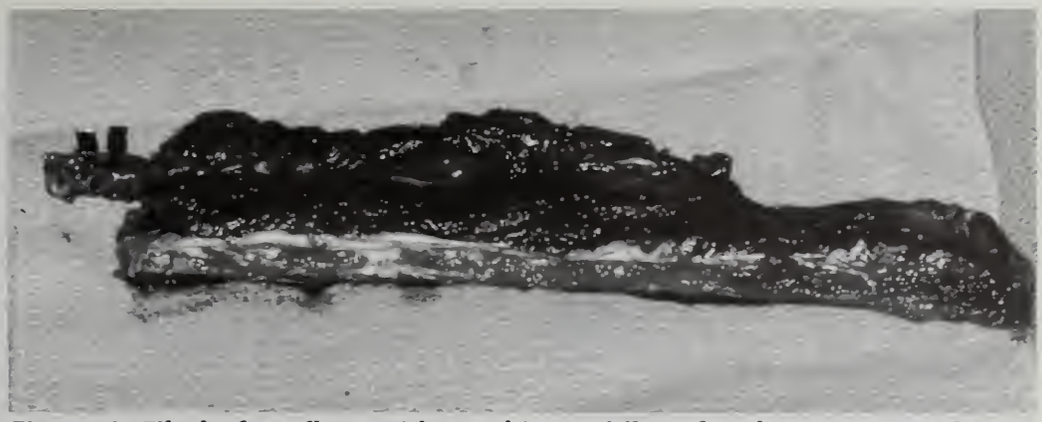

Figure 3. **Fibula free flap (without skin paddle) after harvest. Note large available bone stock in this graft.**

Figure 4. **Lateral view of right lower leg prior to graft harvest indicating placement of skin flap over the middle 1/3 of the fibula.**

Figure 5. **Intraoperative view of fibula free flap after osteotomies. Mandible reconstruction plate may be removed following complete bone healing.**

Table 1: Comparison of Free Flaps Used in Oromandibular Reconstruction.

	Fibula	*Iliac Crest*	*Scapula*	*Radial Forearm*
Bone Available	++++	+++	++	+
Cutaneous Paddle	++	++	++++	+++
Accepts Dental Implants	++	+++	++	+
Sensate Potential	+			+
Donor Site Morbidity	+	+++	++	+
Difficulty of Harvest	++	+++	++++	+

Preoperative angiography or magnetic resonance angiography is required to confirm collateral blood flow to the lower leg. The greatest limitation of this flap is its vascular arrangement, which requires the bone, skin and muscle to be oriented parallel to each other, and can restrict separate orientation of the skin paddle. The fibula bone is osteotomized after its vascular anastomosis and secured using a mandible reconstruction plate (Figure 5). Osteointegrated implants may be placed for dental rehabilitation. Since the fibula contributes little to primary weight bearing, minimal morbidity is seen, as long as approximately 10 cm of distal fibula is left to ensure ankle joint stability.

There are alternatives to the fibula free flap (1,4)(Table 1). Iliac crest bone may be harvested as a free graft based on the deep circumflex iliac artery. It provides a generous segment of curved bone, but the overlying skin paddle is quite thick, and significant donor site morbidity is seen, such as hernias and difficulty with ambulation. The scapular system free flap may be harvested with or without latissimus dorsi muscle. Its greatest advantage is that each component may be independently oriented, but it requires intraoperative repositioning for harvesting. Finally, the radial forearm free flap based on the radial artery provides abundant thin pliable skin, but has a limited amount of bone; so it is generally not used for composite defect reconstruction. The radial forearm free flap, however, is the flap of choice for most isolated soft tissue oral cavity defects.

Conclusion

Microvascular free tissue transfer has had a dramatic impact on the field of head and neck reconstruction. Patients who previously would have been considered unresectable, or left with profound postoperative morbidity, are now managed in a single stage resection/reconstruction with rapid return to competent oral function.

Although each choice of free flap has its relative indications, we believe the fibula free flap provides the most "ideal" graft for the composite anterior oromandibular defect. Further refinements in flap techniques, such as the use of sensate flaps, will further improve postoperative function in this patient population. Hopefully, future advances in tumor biology and adjuvant therapy will improve the overall outcome of these patients as well.

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Imperforate anus: An unusual presentation of a common disease

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Abstract

Imperforate anus is a common problem facing the pediatric surgeon. Most cases of imperforate anus are discovered at birth during the initial physical examination and are corrected early. The pediatric population also accounts for 80% of all cases of ingested foreign bodies. Most of these pass through spontaneously and the treatment is observation. In this article, we present the case of a seven-month-old child in whom failure to pass a swallowed coin led to the diagnosis of imperforate anus. This case illustrates an uncommon presentation of a common disorder and emphasizes the importance of vigilance and careful physical examination in the newborn.

Introduction

An imperforate anus is usually discovered at birth or shortly thereafter with physical examination being the cornerstone of diagnosis (1). In later ages, imperforate anus may present as constipation or other abnormalities of bowel function. The oldest reported case is of a 7-year-old who presented with abdominal swelling and persistent watery diarrhea with flatus (2).

In this paper we discuss an unusual presentation of imperforate anus that was successfully treated.

Case report

A 7-month-old Caucasian female weighing 9.97 kg was referred to our pediatric surgery clinic. She had been born full-term in a hospital and had been regularly having pediatric follow up. She was breastfed and averaged two stools per day which the mother described as being "normal."

Seventeen days earlier, this infant had been taken to her pediatrician because she had swallowed a penny. Initial X-ray showed the penny in the stomach (Fig. 1). The pediatrician then followed it through the gastrointestinal tract with serial films, which showed transit of the coin up to the rectum (Fig. 2). For five days the infant had been straining to stool and crying without any result. The mother denied a history of hematochezia, melena, vomiting or weight loss.

Physical examination revealed a healthy infant with a soft, non-distended abdomen and normoactive bowel sounds. Examination of the perineum revealed normal genitalia but no normal opening for the anus. Instead, a fistulous opening was found just posterior to the introitus. On questioning, the mother admitted that the pediatrician had told her that her child had a "small" anal opening.

We chose a staged approach with initial colostomy rather than a primary anoplasty due to the large amount of stool present in the dilated rectum. Hegar dilators were passed in the anal opening up to size 13 and the coin was extracted. An end colostomy was then performed with a distal mucous fistula. One month later, she underwent a posterior sagittal anoplasty using stimulator probing to define the site of the neo-anus. Serial dilatation of the neo-anus was carried out and two months later she underwent closure of the colostomy. At two months follow up, the child was doing well.

***Figure 1.* X-ray showing the coin in the child's stomach.**

***Figure 2.* X-ray showing the coin lodged in the rectum.**

Discussion

Imperforate anus is not an uncommon problem facing the pediatric surgeon with an incidence of 1 per 4,000 to 5,000 live births (3). The diagnosis of imperforate anus depends on careful physical examination of the newborn infant (Fig. 3).

An anomalous or absent anus is usually diagnosed at birth or shortly thereafter. Occasionally a deep anal pit and complete membrane or web may be missed, but these present during the first few days when the infant fails to pass meconium (1). With early diagnosis and surgical correction, the results are favorable in the absence of other physical abnormalities.

Current recommendations for this condition include early colostomy with delayed repair for the high types and primary repair for the low types (4). Perineal inspection and urinalysis to evaluate the presence of feces in urine provide sufficient clinical evidence to determine whether the patient needs a colostomy in 80%-90% cases. It is important to wait 16-24 hours before making a decision as meconium is not seen in the perineum until then (4).

Even though our patient presented with a low type of lesion, we decided to perform a staged repair because she was too old for a primary anoplasty and the fact that there was such a large amount of stool in the rectum. We used the Pena procedure, which has success rates approaching 100% as measured by voluntary bowel movements in patients with a low malformation and a normal sacrum (5).

Ingestion of foreign bodies in the pediatric population accounts for 80% of all foreign body ingestions. This is especially common in the first two years of life at the height of orolingual curiosity (6). Once an object has passed through the esophagus into the stomach and there are no other problems, the treatment is observation. Ninety-five percent of these objects will travel through the gastrointestinal tract and be extruded within 24-48 hours. Indications for operative removal include abdominal pain, vomiting, blood in stools or failure to pass the foreign body in 4-5 weeks (1).

Figure 3. **Detailed examination of the perineal area before surgery.**

Conclusion

Although the two problems taken independently have been reported frequently, we were unable to find a report where failure of passage of a swallowed foreign body led to the diagnosis of imperforate anus. We present this case to illustrate an uncommon presentation of a common disorder and emphasize the importance of vigilance and careful physical examination in the newborn.

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Diagnosis of pulmonary embolus by Spiral CT: A case study

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Abstract

A thirty-eight-year old immunosuppressed woman presented with respiratory distress and was diagnosed with Pneumocystis Carinii Pneumonia. Pulmonary embolism was also suspected on clinical grounds. A Ventilation-Perfusion Scan was indeterminate. Contrast-enhanced spiral computed tomography of the chest confirmed the presence of a central pulmonary embolus and helped to avoid pulmonary angiography in this critically ill patient.

Introduction

Pulmonary Angiography is considered the gold standard for definitive confirmation or exclusion of pulmonary embolism (PE). However, physicians are often reluctant to proceed with angiography due to concern over increased morbidity and mortality. Therefore, PE may be underdiagnosed and aggressive treatment with thrombolysis or surgery underutilized.

We report a case showing an alternative diagnostic approach to PE that is relatively safe and can be very useful in certain clinical situations.

Case report

A 38-year-old Caucasian woman with a history of stage IV metastatic breast cancer presented to the emergency room with a four-day history of high-grade fever, chills, non-productive cough and increasing shortness of breath. She had received her last course of chemotherapy one year earlier and was being treated with anastrozole. She had recently completed a course of oral prednisone for spinal cord compression due to vertebral metastasis. She had been ambulatory at home prior to the onset of this illness.

This patient's physical examination showed a well-developed woman with cushingoid appearance, in moderate respiratory distress. Her temperature was 39C, pulse 104/min, respiratory rate 25/min, and BP 130/60 mm Hg. Breathing was shallow and labored with coarse crackles in the left upper lung field. The heart rate was rapid, but no murmurs were present. She had no calf tenderness or Homan's sign. Bilateral lower extremity pitting edema was present.

Arterial blood gases breathing room air were: pH 7.5; pCO2 34 mm Hg; pO2 41 mm Hg and O2 saturation 81%. On 2L of oxygen, her saturation improved to 95%. The white cell count was 3300/ml with 75% neutrophils, 14% bands, 2% lymphocytes, 5% neutrophils. PT/PTT were normal. CT of the thorax confirmed the presence of bilateral infiltrates and clearly demonstrated a partially obstructing thrombus in the main pulmonary artery extending to the right lower lobe branch (Figure 1).

She was treated with a combination of antimicrobial agents, a percutaneous Greenfield filter and heparin. She eventually recovered and was discharged home.

Discussion

Prompt and accurate diagnosis of pulmonary embolism is difficult due to the invasive nature of pulmonary angiography. Lack of specificity of pulmonary scintigraphy and other supportive tests further add to this problem. This is especially true of cases where co-existing pulmonary disease impairs the ventilation study and yields an indeterminate ventilation-perfusion scan (V-Q scan).

In such situations, a spiral CT offers a new diagnostic option, more accurate than a V-Q scan and safer than pulmonary angiography. The name helical or spiral CT comes from the "tracing of a helix" by the X-ray beam on the outside of the patient as they pass through the scanner. Contrasting spiral CT with conventional CT best illustrates this scanning technique.

Conventional CT imaging requires a stationary body part during X-ray exposure, while spiral CT allows continued patient motion during X-ray exposure. For conventional CT imaging, the patient inspires, followed by a 1-2 second X-ray exposure. The patient exhales while the scanner table moves to a new position for the next scan. This process requires several seconds per image. Spiral CT requires a prolonged breath-hold for optimal image quality, followed by continuous X-ray exposure during a 20-30 second scan of an entire body part. A volume of data is acquired rather than a single image. Scanning times are therefore reduced, making for improved patient tolerance. Motion artifact and

Figure 1. **CT thorax showing partially obstructing thrombus in the right main pulmonary artery with extension to lower lobe branch.**

discontinuity in contiguous images is minimized. The speed of this technique allows the central pulmonary vasculature to be scanned during a single breath-hold, allowing for detection of pulmonary emboli (1).

A number of studies evaluating the use of spiral CT have been reported that clearly indicate the benefits of this technique in diverse clinical situations. Spiral CT is a safe, non-invasive procedure that can be performed in severely ill patients. Specificity values have been reported to range from 89% to 100% with a mean of 97.6%. Values for sensitivity cluster around 95.5% (2).

Van Erkel et al (2) compared 15 diagnostic pathways for the work-up of PE. Based on a cost-effectiveness analysis, he found lower extremity ultrasound followed by spiral CT to be the strategy of choice. When analyzing dollars per life saved, the most effective strategies all contained spiral CT. For comparison, the sensitivity and specificity values for conventional angiography are 98% and 97%, respectively. The rates of mortality (< 0.001%) and morbidity (0.22%) for spiral CT, based on the expected adverse reactions to ionic contrast media, may actually be an overestimation considering the growing use of safer contrast agents (2). For conventional angiography, the PIOPED study reported mortality and morbidity rates of 0.5% and 1.0% respectively (3).

These data, therefore, suggest that substituting spiral CT for conventional angiography is likely to improve mortality and cost-effectiveness in the work up of PE. Another important advantage of spiral CT over angiography and V-Q scan is that it allows evaluation of other structures within the thoracic cavity including the lung parenchyma and the mediastinum. This is especially helpful in clinical situations where other conditions coexist. Two-thirds of the patients with clinically suspected PE receive an additional diagnosis (4). Use of spiral CT in these situations may eliminate the need for additional imaging studies, further lowering the cost of the diagnostic work-up.

Although beneficial in many ways, spiral CT is not without limitations. Technical difficulties are encountered at variable rates depending, to some extent, upon the expertise of the staff. On average the technical failure rate is around 4% (5). The major limiting factor is severe dyspnea which can lead to marked motion artifact. Some 10% of CT exams are inconclusive due to breathing artifact (5).

Since the work of Howell et al (6) has shown an increase in pulmonary vascular resistance in both high and low lung inflation states, some authors suggest imaging after breath-holding near expiration rather than moderate inspiration (5). Spiral CT may reduce the number of inconclusive studies.

Additionally, spiral CT is best suited for identifying PE in the proximal pulmonary vascular tree (7). To our knowledge there are no valid data about the proportion of patients with PE limited to the sub-segmental vessels. If suspicion remains high for PE with normal CT findings, pulmonary angiography with attention to distal pulmonary vessels is recommended (8).

Conclusion

In conclusion, based on the review of available literature and our own experience, we consider spiral CT to be a safe and accurate noninvasive diagnostic test for detection of PE. It should replace V-Q scan as the first diagnostic test in suspected PE for patients with co-existing lung disease.

Spiral CT can also be reasonably interposed between intermediate probability V-Q Scan and pulmonary angiography in the work-up of PE in most other clinical situations.

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Sporck elected editor of *WV Medical Journal*

Charleston Otolaryngologist F. Thomas Sporck, M.D., F.A.C.S., was elected editor of the *West Virginia Medical Journal* by the WVSMA Council on Nov. 21 after a unanimous recommendation from the members of WVSMA Publication Committee. Dr. Sporck fills the post held by Dr. Stephen D. Ward, who died on Oct. 7 after serving as editor since 1976.

Dr. Sporck has been an associate editor for the *Journal* since January 1998 and chairman of the WVSMA's Legislative Committee since 1990. After he was named editor, Dr. Sporck resigned as chairman of the Legislative Committee to devote full attention to the *Journal*.

Dr. Sporck received a B.S. degree from Otterbein College in 1967 and his M.D. degree from the WVU School of Medicine in 1972. He remained at WVU for his surgery internship and residency in otolaryngology, and then completed fellowships in otolaryngic pathology at the Armed Forces Institute of Pathology, in cleft lip and palate at the University of Iowa, and in facial plastic and reconstructive surgery with Dr. Walter Berman in Beverly Hills, Calif. He served in the U.S. Army Reserves from 1973-81.

Sporck

Since July 1, 1980, Dr. Sporck has been in private practice with Ear, Nose & Throat Associates of Charleston, Inc. He is board certified by the American Board of Otolaryngology and is on staff at Saint Francis Hospital, where he is chairman of the Ethics Committee and a past chief of surgery. Dr. Sporck is also on the staff at Charleston Area Medical Center and is on the consulting staff at Thomas Memorial Hospital and at Ruby Memorial Hospital in Morgantown.

A fellow of the American Academy of Otolaryngology - Head and Neck Surgery Inc. and the American College of Surgeons, Dr. Sporck is a past president of the WV Academy of Otolaryngology and a member of the AMA. In addition to his years of involvement with the WVSMA's Legislative Committee, Dr. Sporck serves on the WVSMA's Insurance Committee and is a former member of the board of directors for WESPAC. He is also a clinical professor at the WVU School of Medicine.

Dr. Sporck's wife, Vicky, is a very active member of the Kanawha County Medical Alliance. The Sporcks have a son, Aaron, who is a junior at Furman University, and a daughter, Sarah, who is in the 10th grade at George Washington High School.

Cordell named chairman of Legislative Committee

Charleston radiologist Ronald E. "Gene" Cordell, M.D., who served as president of the WVSMA from 1996-97, has been elected chairman of the WVSMA's Legislative Committee. Dr. Cordell replaces Dr. F. Thomas Sporck, who resigned to assume duties as the new editor of the *West Virginia Medical Journal. (See above article).*

Dr. Cordell has been a member of the Legislative Committee since 1991, and served from 1992-94 as chair of its Subcommittee to Evaluate Health Care Policy. In addition, Dr. Cordell is currently chairman of the WVSMA's Constitution and Bylaws Committee, and is a past president of Kanawha Medical Society.

Cordell

A native of Nashville, Dr. Cordell received his M.D. in 1975 from the University of Tennessee College of Medicine in Memphis, where he also studied pediatrics and completed a residency in radiology. In 1981, Dr. Cordell moved to Charleston to join Associated Radiologists, Inc.

A fellow of the American College of Radiology, Dr. Cordell serves as one of the ACR's delegates to the AMA. He is a councilor to the ACR from the West Virginia Radiological Society. He has a Certificate of Added Qualifications in Angiography and Interventional Radiology.

Dr. Cordell and his wife, Joann, have two children, Chad and Andrea.

Physician/Public Session at Mid-Winter to focus on *"Drug Advertising/Use of Formularies"*

Canfield

Sweeney

Cheatham

Crotty

Yingling

"Drug Advertising/Use of Formularies" is the title of this year's Physician/Public Session at the WVSMA's Mid-Winter Clinical Conference, January 20-23, at the Embassy Suites in Charleston. This Physician/Public Session will take place on Friday, Jan. 21 at 7 p.m. and will be moderated by **Jack Canfield,** vice president of Charles Ryan Associates and Ryan-McGinn-Samples Research in Charleston.

Speakers for this event will be **Harry Sweeney,** chairman of Dorland Sweeney Jones, Inc., a marketing communications and public relations firm with offices in Philadelphia and San Francisco; **Teddy Cheatham,** president and CEO of Carelink Health Plans, Inc.; **Glenn Crotty, Jr., M.D., F.A.C.P.,** executive vice president & CEO of Camcare, Inc.; and **Kevin W. Yingling, R.Ph., M.D., F.A.C.P.,** program director of the Internal Medicine Residency Training Program at the Marshall University School of Medicine in Huntington.

These four speakers are briefly profiled beginning at right. A registration form for this year's Mid-Winter Clinical Conference, as well as a schedule of meeting highlights and other conference materials are published in this issue beginning on page 316.

To register by phone or obtain other information about the Mid-Winter Clinical Conference, contact the WVSMA at (304) 925-0342. For room reservations at the Embassy Suites, dial 1-800 Embassy or 347-8700.

Speakers profiled

Mr. Sweeney is chairman of Dorland Sweeney Jones, Inc., a marketing communications and public relations firm with offices in Philadelphia and San Francisco specializing in health care products and services.

Prior to acquiring the consumer-oriented Dorland Advertising agency in the early 1970s with his life- and business-partner, Rita Sweeney, Mr. Sweeney held various positions with both clients (Lederle Laboratories and E.R. Squibb & Sons) and agencies (Sudler & Hennessey; Frohlich; Klemtner; and the predecessor agency to Rubin-Ehrenthal) building experience in a variety of drug, device, diagnostics, and health services categories.

In 1991, Mr. Sweeney was a founding member and chairperson of the Medical Advertising Committee of the 4As (American Association of Advertising Agencies.) He is also a founding board member of the Coalition for Healthcare Communications, and president-elect of the Healthcare Marketing & Communications Council.

Mr. Sweeney holds a B.S. degree from Villanova University and a J.D. from New York University.

Mr. Cheatham received B.S. degrees in finance and personnel management from the University of Arizona in 1977. He joined the U.S. Army and served as a commissioned officer until 1988, receiving his M.B.A. at Troy State University in Ft. Rucker, Ala. in 1985.

From August 1988 until November 1995, Mr. Chatham gained a wealth of managed care experience working for companies such as Aetna, FHP, Inc. and Prudential Insurance Company of America in Los Angeles, and during this time he also obtained his J.D. from the Whittier College School of Law. He then relocated to Mississippi to become a part of SEMCO, where he worked for nearly four years before moving to Charleston in October 1999 to assume his current post as president and CEO of Carelink Health Plans, Inc.

Dr. Crotty received his M.D. from the West Virginia University School of Medicine in 1976. He did a residency in internal medicine at Charleston Area Medical Center and a residency in dermatology at the University of Cincinnati, then completed a fellowship in endocrinology and metabolism at WVU, Charleston Division and CAMC.

In 1982, Dr. Crotty began practicing endocrinology in Charleston and was appointed a clinical assistant professor of medicine at WVU, Charleston Division. From Jan. 1, 1995 to Jan. 1, 1998, Dr. Crotty also served as medical director of Carelink Health Plans, Inc. He ceased clinical practice Jan. 1, 1998, when he was named executive vice president and chief medical officer of Camcare and CAMC. In June, Dr. Crotty assumed his current post as executive vice president and chief operating officer of Camcare and he

still maintains a teaching position at WVU, Charleston Division.

A fellow of the American College of Physicians, Dr. Crotty has been a very active member of the WVSMA and is a past president of the Kanawha Medical Society. During his career, Dr. Crotty has served on the WV Legislative Committee on Uncompensated Health Care, on the Legislative Committee for Medicaid and on the Governor's Advisory Committee for the Public Employees Insurance Board.

Dr. Yingling received a B.S. degree from the WVU School of Pharmacy in 1981 and then obtained his M.D. from the Marshall University School of Medicine in 1985.

Dr. Yingling did his internship and residency in internal medicine at the University of Cincinnati Medical Center, where he also did a research fellowship in the Division of General Internal Medicine. After his fellowship, Dr. Yingling taught at the University of Cincinnati for a year and was a visiting scholar at the Cambridge University School of Clinical Medicine in Cambridge, England.

In 1990, Dr. Yingling moved to Huntington to join the faculty of the Marshall University School of Medicine, where he is currently medical director of the Center for Pharmacologic Study, as well as program director of the Internal Medicine Residency Training Program and a consulting pharmacist. During his career at MU, Dr. Yingling has twice received the Faculty Clinician of the Year Award and was named Professor of the Year for 1992-93. Recently, he completed a sabbatical in clinical pharmacology at the University of Southampton in Southampton, England.

A diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians, Dr. Yingling is the co-author of two chapters for the book *"Becoming a Physician - A Primer for Students,"* which is edited by Drs. Maurice Mufson and Shirley Neitch of MU.

Controversies surrounding PSA screenings, C-sections/VBACs highlight Second Session

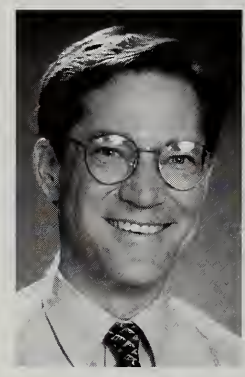
The Second Scientific Session during the WVSMA's Mid-Winter Clinical Conference at the Embassy Suites is devoted to *"Controversies in Medicine,"* and it will feature lectures on *"Prostate - PSA Screening/Diagnosis"* and on *"C-Section/VBAC."* This session will be moderated by **Robert M. D'Alessandri, M.D.**, vice president for health sciences and dean of the WVU School of Medicine, and it will take place Saturday, Jan. 22 at 9 a.m.

Rocco A. Morabito, M.D., F.A.C.S., a clinical associate professor of urology at West Virginia University and a clinical associate professor of surgery at Marshall University, will deliver the first presentation on the pros of PSAs. After Dr. Morabito's lecture, *"PSA — Uses and Abuses,"* **Shawn A. Chillag, M.D.**, residency chairman and academic chairman of the Dept. of Medicine at Greenville Hospital System in Greenville, S.C., will offer the opposing viewpoint with *"PSA — Technology Before Wisdom."*

Following a break, this session will reconvene with the lecture *"Vaginal Birth After Caesarian Section: Is It Really Safe?"* by **Wayne B. Conover, M.D.**, of University Health Associates in Charleston. This talk will focus on the pro viewpoint concerning this subject and then **David G. Chaffin, Jr., M.D.**, associate professor and director of the Division of Maternal-Fetal Medicine at the Marshall University School of Medicine, will present his differing views in a lecture entitled *"VBAC: Primum Non Nocere?"*

Morabito

Chillag


Conover

Chaffin

To register for this year's Mid-Winter Clinical Conference or obtain more information, turn to pages 316-320 in this issue or phone the WVSMA at (304) 925-0342.

Speakers highlighted

Dr. Morabito is a native of Huntington who received his M.D. from West Virginia University in 1976, where he also completed an internship and residency in general surgery and a residency in urology.

Since 1981, Dr. Morabito has been in private practice with Huntington Urological Association, Inc. He is on the staffs at St. Mary's Hospital, Cabell Huntington Hospital, Huntington Surgical Center, HCA River Park Hospital, Putnam General Hospital, and Charleston Area Medical Center.

A clinical associate professor and acting chief of urology at the Marshall University School of Medicine, Dr. Morabito is also a clinical associate professor of urology at the West Virginia University in Morgantown. He is a diplomate of the National Board of Medical Examiners and the American Board of Urology, a fellow of the American College of Surgeons and a past president of the West Virginia Urological Society.

Dr. Chillag received his M.D. from West Virginia University in 1973. He completed his internship in internal medicine at Charleston Area Medical

Center and did his residency in internal medicine at WVU, Charleston Division.

After his residency, Dr. Chillag did a fellowship at WVU in pulmonary medicine and joined the faculty as an assistant professor in 1977. He served as chairman of the Division of General Internal Medicine at WVU from 1978-79, then practiced at Davis Memorial Hospital in Elkins for a year.

In 1980, Dr. Chillag relocated to Logan, where he first practiced at Guyan Valley Hospital and later worked as medical director at Logan Park Care Center for two years. From 1982-88, Dr. Chillag taught at the University of South Carolina and then returned to West Virginia to become residency director of the Dept. of Medicine at WVU, Charleston Division.

For the next 10 years, Dr. Chillag was a prominent member of the WVU faculty and CAMC staff. He served as professor and chairman of the Dept. of Medicine at WVU from 1995-98 and as the Warren Point Chair of Medicine from 1995-98, then he moved back to South Carolina to accept his current post as academic chairman and residency director of the Dept. of Medicine for Greenville Hospital System.

Dr. Conover obtained his M.D. from the University of California at San Diego in 1977. He completed his internship and residency in obstetrics and gynecology at the U.S. Naval Hospital in San Diego and then did a fellowship in maternal-fetal medicine at the University of California Medical Center in San Diego.

From 1983-86, Dr. Conover was on staff at the Dept. of Obstetrics and Gynecology at the U.S. Naval Hospital in Portsmouth, Va., and was an assistant professor at Eastern Virginia School of Medicine in Norfolk, Va. In 1986, he became head of the Dept. of Obstetrics and Gynecology at the U.S. Naval Hospital in Orlando and then moved to Lexington, Ky., where he was an assistant professor and director of Maternal-Fetal Medicine at the University of Kentucky.

From 1988-96, Dr. Conover held positions as director of perinatal medicine at the Iowa Methodist Medical Center in Des Moines, Iowa, and at the John Muir Medical Center in Walnut Creek, Calif. In 1996, he moved to Charleston to assume his current posts as an associate professor and as director of obstetrics and head of the Divison of Maternal/Fetal Medicine at WVU, Charleston Divison.

Dr. Conover is board certified by the National Board of Medical Examiners, the American Board of Obstetrics and Gynecology, and the American Registry of Diagnostic Medical Sonographers. He is a fellow of the American College of Obstetrics and Gynecology.

Dr. Chaffin earned his M.D. at the Johns Hopkins University School of Medicine in 1984. He did his postgraduate training in obstetrics and gynecology at Vanderbilt University Center in Nashville from 1984-88.

Dr. Chaffin taught at the University of Arizona in Tucson from 1988-94 and served as a fellow in maternal-fetal medicine for two years. He relocated to Charleston in 1994 to become director of maternal-fetal research and an assistant professor of ob/gyn at WVU, Charleston Division and CAMC. In August 1998, Dr. Chaffin accepted his present role as an associate professor of ob/gyn and director of the Division of Maternal-Fetal Medicine at the Marshall University School of Medicine in Huntington.

A fellow of the American College of Obstetrics and Gynecologists, Dr. Chaffin is also a member of the American Institute for Ultrasound in Medicine, the Society of Perinatal Obstetricians and the WVSMA.

Alzheimer's disease topic of Lunch & Learn at Mid-Winter

"Alzheimer's Update" is the title of the Lunch & Learn CME program which will be presented on Saturday, Jan. 22 at noon during the WVSMA's Mid-Winter Clinical Conference at the Embassy Suites.

Mark A. Newbrough, M.D., assistant professor of medicine at West Virginia University, Charleston Division, and **James P. Griffith, M.D., F.A.C.P.**, interim assistant dean of student affairs and curriculum at WVU, Charleston Division, will be the speakers for this event, which will be moderated by **Daniel S. Foster, M.D.**, chairman of the WVSMA's Mid-Winter Clinical Conference Committee.

Physicians attending this program will receive 1.5 CME credits. The fee is $35 for WVSMA members and $45 for non-members.

To register, complete the form on page 320 or phone the WVSMA at (304) 925-0342. Space is limited, so early registration is advised.

Newbrough

Griffith

Speakers profiled

Dr. Newbrough earned his M.D. at West Virginia University in 1985, and then did his internship in general surgery and his residency in internal medicine at Charleston Area Medical Center and WVU, Charleston Division.

After his residency, Dr. Newbrough completed a fellowship in geriatrics at WVU in Morgantown, and then returned to Charleston in 1990 to become a clinical assistant professor of medicine at WVU, Charleston Division. He was promoted to his current post as an assistant professor of medicine the following year. In addition, Dr. Newbrough serves as medical director of the Cabin Creek Health Center, where he is a field professor for the Rural Health Education Partnerships Program.

Dr. Newbrough is board certified in internal medicine with added qualifications in geriatrics. He is a member of the American College of Physicians, the American Geriatrics Society and the National Rural Health Association.

In addition to his work at the Cabin Creek Health Center, Dr. Newbrough

cares for patients at WVU's Geriatric Assessment Clinic, University Health Associates and Arthur B. Hodges Center. He and the other faculty at the Geriatric Assessment Clinic are currently involved in a research project on *"Caregiver Perspectives on the Impact of Donepezil in the Treatment of Alzheimer's Disease"* through the WVU Foundation.

Dr. Griffith received his M.D. from the West Virginia University School of Medicine in 1985 and completed post doctoral studies in internal medicine and psychiatry at WVU, Charleston Division and CAMC.

In 1990, Dr. Griffith was appointed to the faculty as an assistant professor of behavioral medicine/psychiatry and as an assistant professor of internal medicine at WVU, Charleston Division. In July 1995, he was promoted to an associate professor and in Oct. 1998, he assuned his current role as interim assistant dean of student affairs and curriculum.

Dr. Griffith is currently on staff at CAMC and Highland Hospital. He is board certified in internal medicine, psychiatry and has added qualifications in geriatric psychiatry.

Dr. Griffith has had five psychiatric articles published in the *West Virginia Medical Journal* and he has spoken extensively on the subject of Alzheimer's disease throughout the state.

Fourth Session to feature lectures on diabetes, bipolar disorder, *"Stump the Audience"* cases

Dr. Lee Neilan

Fink

The Fourth Scientific Session, *"Potpourri of Topics,"* on Sunday, Jan. 23 at 9 a.m. during the WVSMA's Mid-Winter Clinical Conference at the Embassy Suites will begin with the lecture *"Diabetes in the New Millennium: Approaching the ADA Standards of Care"* by **Frank L. Schwartz, M.D., F.A.C.E.**, who specializes in endocrinology and metabolism in Parkersburg.

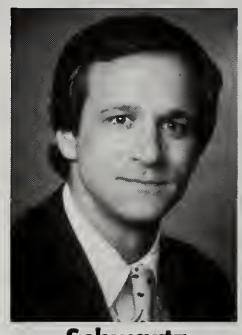
Following this presentation, **Kenneth M. Fink, M.D., F.A.P.A.**, of Huntington, will deliver the lecture *"Bipolar Disorder: Proper Diagnosis and Treatment Update."* This lecture is being presented in memory of Charleston psychiatrist Dr. Lee Neilan, who died on Feb. 2, 1999.

Dr. Neilan was a very active member of the WVSMA, who served on Council and on the Legislative Committee for many years. She was chairman of the WVSMA's 1993 Annual Meeting Program Committee.

Dr. Neilan was also very involved with Kanawha Medical Society and served as treasurer and on its Council during her career. She was a fellow of the American Psychiatric Association and a past president of the West Virginia Chapter of the American Psychiatric Association.

Dr. Neilan and her husband, George, have three children who are all physicians — Dr. Robert Neilan of San Diego; Dr. Edward Neilan of Chestnut Hill, Mass.; and Dr. Joyce Neilan of West Chester, Pa. In Dr. Neilan's honor, a special award will be presented to Mr. Neilan before Dr. Fink's lecture.

After Dr. Fink's lecture and a break, the Fourth Scientific Session will reconvene with the popular *"Stump the Audience"* segment. **Warren Point, M.D.**, professor emeritus of the WVU School of Medicine, and **Robert J. Marshall, M.D.**, a clinical professor of medicine for WVU and Marshall University, will again act as the facilitators for *"Stump the Audience,"* and they will present special door prizes.



Schwartz

Brick

Latos

Turner

"These are reverse CPCs presented by three excellent faculty members," Dr. Point said. The physicians and their case studies will be: **James E. Brick, M.D.**, the E.B. Flink professor of medicine at WVU in Morgantown - *"A Women with Edema;"* **Derrick L. Latos, M.D.**, Wheeling nephrologist -

"Confusion: The Doctor's Dilemma;" and **Charles E. Turner, M.D.,** Huntington gastroenterologist - *"Why Does This Otherwise Healthy Young Woman Throw Up Every Time She Goes Out to Dinner?"*

Bios on Drs. Schwartz, Fink, Brick, Latos and Turner begin below. For more details about the WVSMA's Mid-Winter Clinical Conference, turn to pages 316-320 or phone the WVSMA at (304) 925-0342.

Speakers highlighted

Dr. Fink received his M.D. in 1972 from the WVU School of Medicine, where he also completed a residency in adult and general psychiatry and a fellowship in child psychiatry.

Since 1976, Dr. Fink has practiced adult, child and adolescent psychiatry in Huntington. He is medical director of the adolescent treatment unit at St. Mary's Hospital, where is also chief of psychiatry.

A clinical assistant professor in the Dept. of Behavioral Medicine and Psychiatry at WVU, Dr. Fink is a fellow of the American Psychiatric Association and a past president of the West Virginia Psychiatric Association.

Dr. Schwartz received his M.D. from WVU School of Medicine in 1978, where he also was a special graduate student in the Dept. of Pharmacology from 1973-78. He did his internship and residency in internal medicine at WVU, and then completed two fellowships in the Division of Endocrinology and Metabolism.

In addition to his endocrinology and metabolism practice with Endocrine Diagnostics, Inc. in Parkersburg, Dr. Schwartz is medical director of the Diabetes Management Center at Camden-Clark Memorial Hospital. He is also on the staffs of St. Joseph's Hospital, Western Hills Rehabilitation Hospital, Marietta Memorial Hospital and Selby General Hospital.

A fellow of the American College of Endocrinology, Dr. Schwartz is a charter member of the American Association of Clinical Endocrinology and a member of many other medical organizations. He is a clinical associate professor of medicine and pharmacology at the WVU School of Medicine.

Dr. Brick received his M.D. from WVU in 1977, and completed his internship and residency in medicine at WVU Hospital. After his residency, Dr. Brick did a fellowship in rheumatology at WVU Hospital and began teaching at WVU.

From 1982-84, Dr. Brick continued his postgraduate studies at the University of Missouri in Columbia with a fellowship in immunology and rheumatology. He returned to WVU in 1984 and joined the Section of Rheumatology as an assistant professor. During his years at WVU, he has advanced through the ranks to his present position as the E.B. Flink Professor of Medicine.

Dr. Brick is board certified in internal medicine and rheumatology and is very active in research. He was medical director for Mountaineer Doctor Television (MDTV) at WVU from 1991-97 and presently serves on the editorial board for *Telemedicine Journal.*

Dr. Latos received his medical degree from the WVU School of Medicine in 1972. He did an internship and was an assistant resident in medicine at Vanderbilt University Hospital in Nashville, where he also completed a fellowship in nephrology and later became chief resident.

Since 1977, Dr. Latos has been in private practice in nephrology/internal medicine in Wheeling, where he is also medical director of Wheeling Renal Care. A clinical professor of medicine at WVU since 1985, Dr. Latos was recently named a clinical assistant professor of medicine at the West Virginia School of Osteopathic Medicine.

A past president of the WVSMA, the Ohio County Medical Society, and the Renal Physicians Association, Dr. Latos is governor of the WV Chapter of the American College of Physicians and is active in many state and national medical organizations.

Dr. Turner obtained his M.D. from the WVU School of Medicine in 1963. He completed an internship in straight medicine, residency in medicine and a fellowship in gastroenterology at Strong Memorial Hospital at the University of Rochester in Rochester, N.Y.

Dr. Turner is a member of the Huntington Internal Medicine Group, Inc. in Huntington and is on staff at Cabell Huntington Hospital and St. Mary's Hospital. He is a consultant in gastroenterology at the VA Hospital in Huntington and is a clinical professor of medicine at the Marshall University School of Medicine.

A past president of the WVSMA and the Cabell County Medical Society, Dr. Turner is a fellow of the American College of Physicians and a recipient of the ACP's Laureate Award. In addition, Dr. Turner is a fellow of the the American College of Gastroenterology and a past governor of the WV Chapter of the ACG.

MA ranked one of Forbes' *"200 Best Small Companies"*

Forbes recently rated Medical Assurance, Inc., the WVSMA's endorsed medical malpractice carrier, as one of *"The 200 Best Small Companies"* in America based on a number of financial measures that help assure policyholders of the company's financial strength. It's the second straight year Medical Assurance has made the list, and it is the only medical professional liability insurer to make the list this year.

"Making the list two years in a row highlights our ability to meet the high expectations of our policyholders," said Chairman A. Derrill Crowe, M.D. "We believe we serve our policyholders best by providing superior service and enhancing our exceptionally strong financial foundation," he added.

For more information about Medical Assurance, call (800) 331-6298 or 346-8228 in Charleston.

Notice

The West Virginia Board of Medicine has available an informative video presentation describing its functions, purpose, processes and staff contacts. WV Board of Medicine members are available to present the 20-minute video with Board of Medicine staff at meetings of county medical societies and other interested groups.

For further information or to schedule a presentation, please contact Ronald Walton, executive director of the WV Board of Medicine at (304) 558-2921.

Mid-Winter Clinical Conference

Highlights

Thursday, January 20

1 p.m. - 3 p.m.	Medical Assurance Loss Prevention Seminar
5 - 6:30 p.m.	*"State Capitol Report: Update on 2000 Legislative Session"* Hosted by WVSMA Legislative Committee
6:30 p.m. - 8 p.m.	**Legislative Reception**
8 p.m.	WVSMA Executive Committee Business Meeting

Friday, January 21

8 a.m.	WVSMA Committee on Medical Education
9:30 a.m. - 11:30 a.m.	*"System98 Educational Session"*
Noon	WVSMA Publication Meeting
Noon - 2 p.m.	Local Health Officer's Luncheon, Hosted by the Bureau of Public Health
1 p.m. - 4:30 p.m.	Exhibit Visitation
1 p.m. -5 p.m.	**FIRST SCIENTIFIC SESSION** *"Thrombolysis in Acute Ischemic Stroke"* Charles H. Tegeler, IV, MD *"Influenza"* Thomas C. Rushton, MD "*Update on Telemedicine in West Virginia"* Christopher Budig *"Congestive Heart Failure"* William H. Carter, MD
3:30 p.m.	WVSMA Scientific & Education Sessions Committee Meeting
4:30 p.m. - 5:30 p.m.	WESPAC Board Meeting
4:30 p.m. - 5:30 p.m.	Marshall University Alumni Board of Directors Meeting
5:30 p.m. - 7 p.m.	Reception, co-hosted by West Virginia University and Marshall University Schools of Medicine
7 p.m.	**PHYSICIAN SESSION/PUBLIC SESSION** ***"Drug Advertising/Use of Formularies"*** Jack Canfield, Vice President of Charles Ryan, Moderator Harry Sweeney, Chairman and CEO, Dorland Sweeney Jones Teddy M. Cheatham, CEO, Carelink Health Plans, Inc., Glenn N. Crotty, Jr., MD, Charleston, Kevin Yingling, MD, Huntington

Saturday, January 22

7:30 a.m. - 8:30 a.m.	WVSMA Surgery Section Breakfast Meeting
8:30 a.m. - 5 p.m.	Exhibit Visitation
8:30 a.m. - 4:30 p.m.	WVSMA Medical Student Section Meeting and Luncheon
9 a.m. - Noon	**SECOND SCIENTIFIC SESSION, "Controversies in Medicine"** *"Prostate – PSA Screening Diagnosis"* *"PSA – Uses and Abuses"* Rocco A. Morabito, MD *"PSA – Technology Before Wisdom"* Shawn A. Chillag, MD *"C-Section /VBAC"* *"Vaginal Birth after Cesarian Section: Is it Really Safe?"* Wayne B. Conover, MD David G. Chaffin, Jr, MD, *"VBAC: Primum non nocere"*
10 a.m. - 3 p.m.	WV Urological Society Meeting
Noon - 4 p.m.	WV Psychiatric Association Meeting
Noon	WV State Society of Anesthesiologists
Noon - 1:30 p.m.	**Lunch & Learn - *"Alzheimer's Update"*** Daniel S. Foster, MD, Moderator; James P. Griffith, MD; Mark A. Newbrough, MD
1:30 p.m. - 5 p.m.	**THIRD SCIENTIFIC SESSION, "Palliative Care"** Introduction and Case Presentation *"I Feel Like a New Person"* Alvin H. Moss, MD, FACP *"Treating the Patient in the Final Hours"* Sue C. Warren, MD, FACP *"Communicating Bad News to Patients and Families"* Stephen C. Hines, PhD *"The Ethics and Law of Pain Management"* Alvin H. Moss, MD, FACP **Case Discussion and Question and Answer Session**
8 p.m. - Midnight	**Sandy Sowell Entertainment will present her famous "Game Show Mania"** ***Hosted by Medical Assurance of West Virginia*** Be a contestant or sit back and enjoy the show. The evening will be packed with trivia questions, prizes and lots of fun! Salon A, B, C

Sunday, January 23

7 a.m.	WVSMA Council Breakfast Meeting
8:30 a.m. - 11 a.m.	Exhibit Visitation
9 a.m. - Noon	**FOURTH SCIENTIFIC SESSION, "Potpourri of Topics"** *"Diabetes in the New Millenium: Approaching the ADA Standards of Care"* Frank L. Schwartz, MD *"Bipolar Disorder - Proper Diagnosis and Treatment Update"* Kenneth M. Fink, MD *"Stump the Audience"* Robert J. Marshall,MD, Warren Point, MD, Moderators James E. Brick, MD; Derrick L. Latos, MD; Charles E. Turner, MD, Presenters

Don't Wait...Register NOW to

Lunch & Learn

Join us at the Embassy Suites during our 2000 Mid-Winter Clinical Conference for our popular Lunch & Learn program, Saturday, Jan. 22 at Noon. This year's topic will be *"Alzheimer's Update"* Speakers include:

Daniel S. Foster, M.D., Moderator
Mark A. Newbrough, M.D., Charleston
James P. Griffith, M.D., Charleston

The cost for WVSMA members is $35 and $45 for non-members. Physicians will receive 1.5 CME credits for the Lunch & Learn program.

Space is limited, so it is important to register NOW if you plan to attend this informative session. To register, please visit the WVSMA Registration Table prior to the program.

WVSMA

Committed to Excellence
Committed to You

Join us for an evening of trivia fun!

Sandy Sowell Entertainment

presents

"Game Show Mania"

Hosted by

Medical Assurance

West Virginia's Finest Malpractice Insurance

Join us Saturday, Jan. 22 during the WVSMA Mid-Winter Clinical Conference at the Embassy Suites in Charleston. Be a contestant or sit back and enjoy the show. The evening will be packed with trivia questions, prizes and lots of fun! Sandy Sowell describes her newest show as, "like Jeopardy, except designed for *regular* people." Cartoons, nursery rhymes, name that tune, commercials, and pop-culture trivia will be among the categories. Following the game show, Dr. Rano Bofill will provide the laser karaoke from 10 p.m. - Midnight.

Saturday, Jan. 22, 2000

8 p.m. - Midnight

Salons A-C

Hor-d'oeuvres will begin at 8 p.m., entertainment will begin at 8:30 p.m.

Mid-Winter Clinical Conference

WV State Medical Association

Embassy Suites, Charleston, WV

January 20-23, 2000

Register Now!

Name _____

Address _____ City/State/Zip _____

County _____ Specialty _____ Phone _____

Payment by: _____Check _____ VISA _____ MasterCard

Card Number_____

Expiration Date_____

Signature_____

• Cancellation Policy: There will be a $50 administrative fee for cancellations after December 15, 1999

If paying by check,
please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364
(304) 925-0342 Toll-free: (800) 257-4747
or FAX to: (304) 925-0345

To receive a special room rate, call the Embassy Suites at (304) 347-8700.

Registration Fees

- ☐ **WVSMA Member — $125**
- ☐ **Non-Member — $175**

Lunch & Learn — Saturday, Jan. 22, 2000
"Alzheimer's Update"
Daniel S. Foster, MD, Moderator

- ☐ **Members (receiving CME Credit) $35**
- ☐ **Non-members $45**

Total Due $_____

CME & Special Events

Camcare Health Educ. & Research Institute

"Back to Work After a Lower Back Injury: A Functional Model"
Jan. 14, 11:45 a.m., Marsha Bailey, M.D., M.P.H., Logan General Hospital, Logan

"Cancer - Winning the Game"
Jan. 18, 12:30 p.m. - Seminar, James N. Frame, M.D., program chairman; 5:30 p.m. - Pre-Game Meal and Entertainment; 7:30 p.m. - Marshall vs. WVU Basketball Game, Charleston Civic Center, Charleston

"Medical Ethics"
Jan. 19, 6 p.m., Mary Lou Lewis, M.D., Man ARH, Man

"Back to Work After a Lower Back Injury: A Functional Model"
Jan. 26, 11:45 am., Marsha Bailey, M.D., M.P.H., Summers Co. ARH, Hinton

"19th Cardiovascular Conference at Snowshoe"
Jan. 31 - Feb. 2, William H. Carter, M.D., F.A.C.C., program chairman, Mountain Lodge Conference Center, Snowshoe

"Issues in Medical Ethics:Basic Certificate Program"
Mar. 3, 8 a.m. - 4:30 p.m., Mary Lou Lewis, M.D., Robert Hall, Ph.D., program chairmen, Camcare Health Education and Research Institute, Education and Training Center, Charleston

"27th Annual Newborn Day"
Mar. 24, 8 a.m. - 4:30 p.m., Stephan R. Maxwell, M.D., program chairman, Robert C. Byrd Health Sciences Center of WVU, Charleston Division Auditorium

Marshall University School of Medicine

"Diagnosis and Treatment of Osteoporosis"
Jan. 19, 7 a.m., James Simon, M.D., Cabell Huntington Hospital

"Salivary Cortisol Measurements for the Diagnosis of Cushing's Syndrome"
Feb. 14, 6:30 p.m., James W. Findling, M.D., Location TBA

"Cushing's Syndrome and Syndrome X: A Diagnostic Dilemma"
Feb. 15, 8 a.m., James W. Findling, M.D., MU Medical Center Auditorium

"Death Investigation: A Training Course"
March 20-21 - Huntington
March 23-24 - Morgantown
Jointly sponsored by the Office of the Chief Medical Examiner, The State of WV, and the Dept. of Forensic Science and The Dept. of Pathology of Marshall University

"Hyperlipidemia in the New Millennium"
March 21, 8 a.m., St. Mary's Hospital, Peter Kwiterovich, M.D.

Robert C. Byrd HSC - Morgantown

"Preparatory Course for Urology Certifying Exam: Part II
Jan. 20-22, Embassy Suites, Pittsburgh

"Cardiology Update"
March 25, Robert C. Byrd HSC, Morgantown

"AIDS in West Virginia"
May 11-13, Lakeview Resort and Conference Center, Morgantown

"Health Access"
May 18-19, Lakeview Resort and Conference Center, Morgantown

"WV State Society of Anesthesiologists Annual Meeting"
May 26-28, The Greenbrier, White Sulphur Springs

"Rural Aging: A Global Challenge"
June 7-11, Charleston Civic Center, Charleston

"Clinical Tropical Medicine and Parasitology"
June 13-Aug. 4, International Health Program, Robert C. Byrd HSC, Morgantown

West Virginia State Medical Association

"WVSMA's 2000 Mid-Winter Clinical Conference"
Jan. 20-23, Embassy Suites, Charleston

Bureau for Public Health News

Pre-Employment Services to provide dental/vision Care

Thanks to a new Pre-Employment Services project, some vision and dental services will soon be available to eligible welfare recipients in West Virginia in order to help them be better physically prepared to enter the workforce.

Officials with the Dept. of Health and Human Resources (DHHR) are actively recruiting dentists and optometrists around the state to participate in the new initiative slated for start-up in January. The project will offer the provision of some dental and vision services to unemployed and low-income individuals who have been identified by a Family Support Specialist as eligible for pre-employment assistance.

"We're very excited about this new opportunity," said Pat Moss, director of the Bureau for Public Health's Office of Maternal and Child Health (OMCH), which administers the program.

"Dental diseases can be debilitating," Moss said. "Over 150 million hours of work are missed each year because of dental problems. Similarly, untreated vision problems can present significant barriers to getting and keeping a steady job. These services can help people to prepare themselves to work, to help them become marketable as potential employees."

About $8 million from the federal Temporary Assistance for Needy Families (TANF) program are being made available through DHHR's Bureau for Children and Families (BCF) in order to fund the Pre-Employment Services project.

"There are so many positives to this strategy," said Jack Frazier, BCF director. We can help people get the care they need to be ready to work. Good physical condition improves self esteem, and so does a good job. The two can improve the overall quality of life for families and children."

Dental reimbursements are made using the Medicaid fee schedule for services. Optometry has a $300 annual benefit - $55 for an exam, $40 to $70 for lenses and $100 for frames.

Dentists and optometrists can be enrolled for participation in the program by contacting OMCH recruitment specialist Ken Selby at 1-800-642-8522.

New office directors assume posts at BPH

The West Virginia Bureau for Public Health is very pleased to announce the appointment of two new office directors.

Andrea Mary Labik, Sc.D, ABMM assumed her post as Director of the Office of Laboratory Services this past October, replacing Dr. Frank Lambert. Labik comes to BPH from the Good Samaritan Hospital Medical Center in West Islip, New York, where she served as the Clinical Microbiologist. Labik also has extensive experience as a teacher and academician, and is a graduate of the University of Pittsburg Graduate School of Public Health.

Barbara S. Taylor is slated to begin her new duties as Director of the Office of Environmental Health Services in late January. She will replace Chris Gordon, Assistant Commissioner, BPH, who has served there as interim director since August. Gordon will return to her full-time post in the Commissioner's Office.

Taylor will leave her position as Chief of the Office of Water Resources at the West Virginia Division of Environmental Protection to join BPH in late January. Taylor graduated from West Virginia University and obtained a Master of Science Degree in Environmental Science from Marshall University Graduate College.

Calendar of Health Observances and Recognition

January

March of Dimes Birth Defects Prevention Month

National Eye Care Month

National Glaucoma Awareness Month

National Thyroid Awareness Month

National Volunteer Blood Donor Month

Healthy Weight Week (16th-22nd)

National School Nurse Day (26th)

February

American Heart Month

National Children's Dental Health Month

National Women's Heart Health Day (1st)

Pride in Food Service Week (7th-11th)

Cardiovascular Professionals Week (13th-19th)

National Condom Day (14th)

Poetry Corner

No Going Back

There is no going back in time
  To days which used to be;
So live your life and live it well.
  Take every opportunity
To savor what you have,
  And give it all your best.
Enjoy the good, improve the bad,
  Then you will certainly be blessed.
Today will be tomorrow's past,
  Just a part of memory;
No going back when it is done,
  So live it joyfully.
Keep memories of times gone by
  While living for today;
Yet face the future full of hope
  While keeping faith along the way.

E. Leon Linger, M.D.

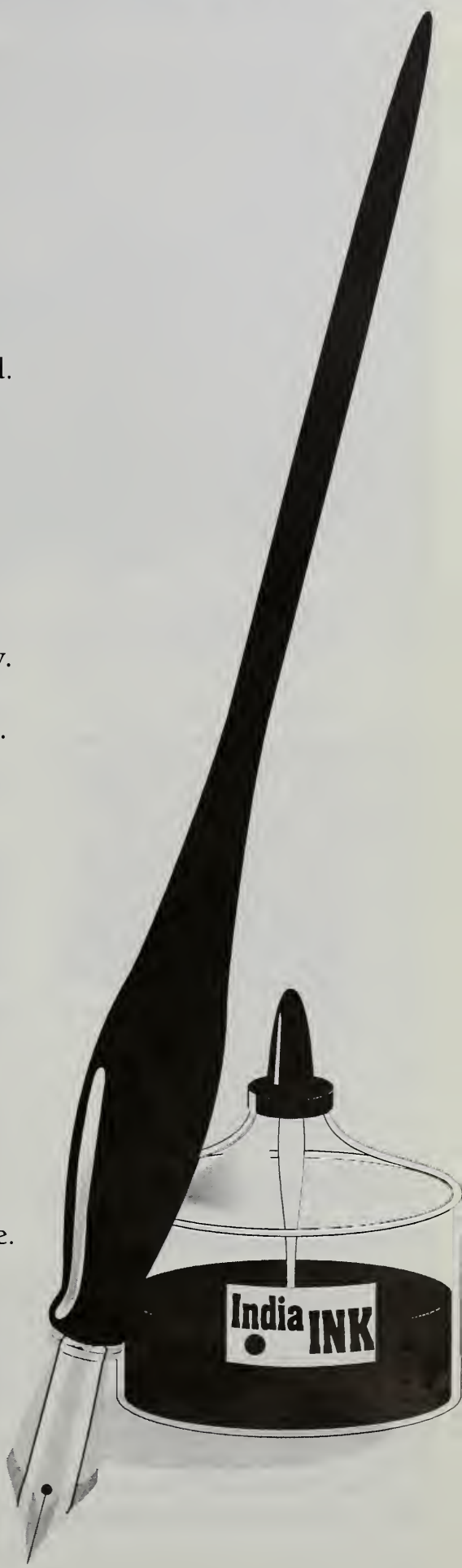
My Daddy

When Daddy signs his name,
  he always writes MD.
That's so everyone will know
  that he belongs to me.

MD means "My Daddy,"
  or something just the same,
and that is why he always
  puts these letters behind his name.

Some letters in his name are small,
  but these are not, you see.
He always writes them big like that
  'cause he's so proud of me.

Anonymous



Robert C. Byrd Health Sciences Center of West Virginia University News

Construction under way on Eye Institute

WVU's Eye Institute will house the most advanced eye care facilities in WV.

Ground has been broken for a new WVU Eye Institute, which will be built next to the Physician Office Center, adjacent to Ruby Memorial Hospital. The building, which will house West Virginia's most advanced eye care facilities, is the result of years of planning and preparation that involved faculty, staff, administrators and people around the state.

The facility will allow the Dept. of Ophthalmology to consolidate faculty offices, labs, teaching spaces and patient treatment areas now scattered among several locations. A special area will be included for the many children and adolescents who are treated for eye disease at WVU.

Palliative care service offered for patients

To address the psychological and spiritual needs of patients with chronic or terminal illness, WVU has started a palliative care consultation service.

"We want to focus on meaningful living and quality of life for our patients," said Alvin Moss, director of the Center for Health Ethics and Law.

For details, call (304) 293-7618.

New family medicine center opens at WVU

Jacques

WVU recently opened the new $3 million Sleeth Family Medicine Center for primary health care.

Located on the the first floor of the Health Sciences Building, this new clinic offers patients a new, more convenient and pleasant location to visit their physicians. The clinic is named for the late Dr. Clark Sleeth, WVU dean of medicine from 1961-70, who retired in 1978 after 49 years at WVU.

"We listened to our patients," said Dr. Mitch Jacques, chair of Family Medicine. "They told us they wanted to see a doctor without a lot of inconvenience. The design of this center is based on making the experience of health care better for each patient."

The 35 exam rooms include several with facilities for patients with limited mobility or other needs. The Center includes space for patient education, a state-of-the-art electronic classroom for med students and others; procedure rooms; a lab facility, and an X-ray suite.

Brick named to Flink Chair of Medicine

Brick

Dr. James Brick has been named the E.B. Flink Chair of Internal Medicine at the WVU School of Medicine.

Dr. Brick is the chair of the Dept. of Medicine. Appointment to the endowed chair is an additional honor, which is a tribute to his career as a physician and teacher.

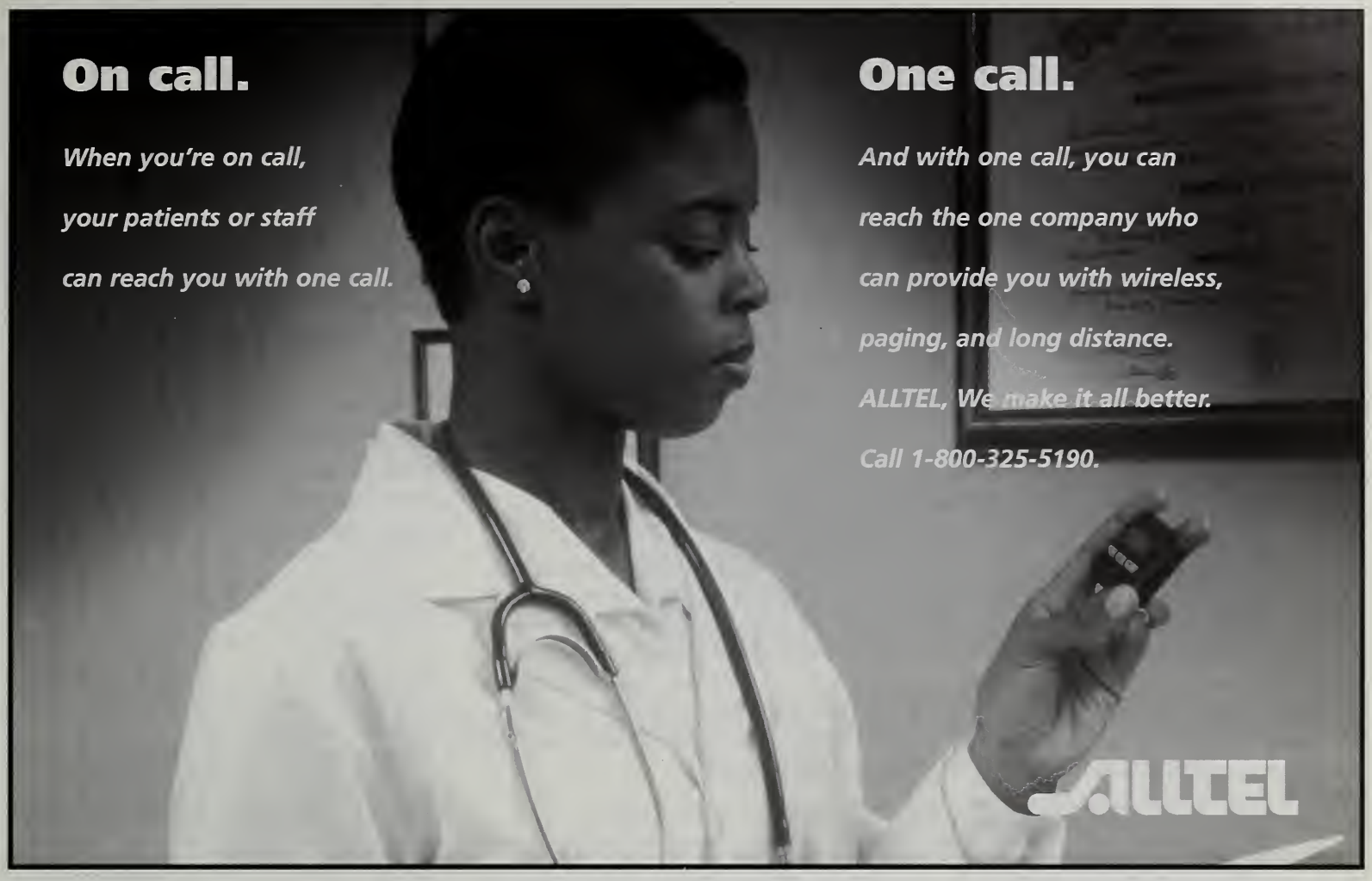
Dr. Brick, a rheumatologist, joined the WVU faculty in 1981. He is widely known for his research in arthritis treatment and in telemedicine, and is the co-founder of the Mountaineer Doctor Television (MDTV) system.

The Flink Chair is named for Dr. Edmund B. Flink, who led the Dept. of Medicine at WVU from 1960-1976.

Cancer Center given $1.5 million donation

The J.F. Allen Company of Buckhannon has donated $1.5 million to support lung cancer research and treatment at WVU. John Crile Allen, the president of J.F. Allen, and his wife, Joyce, made the gift in memory of his parents, who both died of lung cancer.

The Allens' donation will establish the Sara Crile Allen and James Frederick Allen Comprehensive Lung Cancer Program at WVU's Mary Babb Randolph Cancer Center. WVU's comprehensive lung cancer program uses a combined approach to evaluate and treat patients.



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Marshall University School of Medicine News

Marshall awarded telemedicine grant

The School of Medicine has received $307,830 from the USDA's Distance Learning and Telemedicine Grant Program for a project that will provide an educational link to residents of three southern West Virginia counties.

The project is geared toward distance learning in the biomedical sciences at several levels, with ancillary usage as a vehicle for telemedicine consultations and patient education, according to Michael McCarthy, assistant dean for information technology and medical informatics.

The program will link the Southern Mountain Centers in Logan and Williamson, Lincoln Primary Care Center in Hamlin and the Larry Joe Harless Community Center in Gilbert to the School of Medicine. Potentially, the total population of the targeted counties could reap the benefits of the project, the USDA said in announcing the grant.

The project targets the educational needs of a broad constituency, including workers in biotechnology fields and allied health professions (such as forensic law enforcement and pharmaceutical sales), pre-professional students seeking admission to medical school, medical students and residents training in rural clinics, practicing physicians in need of telemedicine consultations and continuing education, and patients who could benefit from disease-specific patient education programming.

The project will make use of an integrated, high-speed, $20 million statewide intranet deployed by Bell Atlantic West Virginia and the Governor's office, McCarthy said, and will use asynchronous transfer mode (ATM) technology to integrate data and video connectivity where appropriate.

According to USDA State Director Bobby Lewis, the project will include a graduate-level biomedical sciences course, videoconferencing among faculty and medical students and residents training in rural clinics, telemedicine consultations, continuing medical education programs, and patient education seminars and programming.

"Everyone who has played a role in promoting and supporting this project should be very proud of what has been accomplished thus far," Lewis said. "The communications lines that are built and maintained today are truly the life lines for our rural communities in West Virginia."

MU, Prestera join in geriatric program

Prestera Center for Mental Health Services, Inc., and Marshall's Department of Psychiatry and Behavioral Medicine have entered a partnership to meet the psychiatric needs of senior citizens.

V. N. Shah, M.D., of Marshall, has become medical director of Prestera's Senior Acucare program, a geriatric partial hospitalization program for seniors who are experiencing an illness that could result in psychiatric hospitalization. He will provide psychiatric assessment and treatment plan development for persons who suffer from acute psychiatric condition such as depression, anxiety, mood swings or psychosis.

The Medicare-based program, which provides an alternative to inpatient hospitalization, is designed to help participants achieve greater social and emotional independence, enhanced self-esteem, and increased ability to function in daily living.

MU doctor profiled in *People* magazine

Marshall pediatrician Dr. Isabel Pino was profiled in the Nov. 29 edition of *People* magazine for her travels to southern West Virginia communities as medical director of a mobile pediatric clinic.

Operated by MU and Valley Health Systems, the mobile clinic visits eight communities in four counties at least once a month. The program started in 1992 with the Children's Health Fund in N.Y. providing the van and Sen. Jay Rockefeller donating $50,000.

"Still, the heart and soul of the Appalachian unit is Pino herself, who leavens her medicine with a warm bedside manner," wrote author Giovanna Breu in the six-page profile. Breu notes Pino strongly emphasizes prevention and nutrition, and consistently quizzes children about their school progress.

"I think of these children as my kids - - I'm very possessive about them," she quotes Pino as saying. "When a child walks in the door, I'm not looking at a possible ear infection. I'm trying to examine their life."

Two faculty named ASH specialists

Dr. Bruce Chertow and Dr. Robert Touchon were two of four West Virginia physicians designated as ASH specialists in clinical hypertension.

The ASH Specialists Program was formed by the American Society of Hypertension to identify and recognize physicians with expert knowledge and skill in the management of clinical hypertension and related diseases.

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West Virginia School of Osteopathic Medicine News

AOA president tours WVSOM campus, delivers address

Dr. Eugene Olivieri, AOA president, addresses the WVSOM community.

Eugene A. Olivieri, D.O., president of the American Osteopathic Association, recently toured the WVSOM campus and spoke to students and faculty members.

"My goals as AOA president are threefold," said Dr. Olivieri. "First, I would like to raise awareness of osteopathic medicine and its physicians around the country. Secondly, I want to accentuate our profession's distinctiveness. As osteopathic physicians, we have something extra to help treat patients - osteopathic manipulative treatment.

"My third goal is unification. It would behoove the osteopathic profession to unite its many different organizations across the nation and work for a common goal," he added, pointing out AOA's new slogan - *"DOs: Physicians Treating People, Not Just Symptoms."*

Federal grant allows expansion of Alumni Center at WVSOM

WVSOM has been awarded a $900,000 federal grant that will transform an on-campus conference center into a large community center. The grant was made possible by the efforts of U.S. Representatives Nick Rahall and Alan Mollohan.

"Obviously, we are thrilled with this news," said WVSOM President Olen E. Jones, Jr., Ph.D. "The grant will fund expansion of the existing Roland P. Sharp Alumni Conference Center into a more comprehensive community center to be used for school functions and community activities."

Dr. Jones also emphasized the role the Greenbrier Military School Alumni Association played in securing the grant. "The grant was instigated by GMS alumni members, and I want to thank them for their efforts. We're fortunate to have such a group working with us to improve the quality of life in this area," he added.

Boxwell receives ACOFP fellow award

George Boxwell, D.O., F.A.C.O.F.P., received his designation as a Fellow during the American College of Osteopathic Family Physicians' annual meeting at the American Osteopathic Association's Convention in San Francisco.

Dr. Boxwell, chairman of the Clinical Science Division and an associate professor of family practice at WVSOM, earned his doctor of osteopathy degree from Kirksville College in Kirksville, Mo.

Study shows OMT is effective therapy for low back pain

People with chronic low back pain who were treated with osteopathic manipulation used less medication and recovered as well as those who received standard allopathic medical care, according to a study published in *The New England Journal of Medicine.*

Study results show that the two different treatment regimes were equally effective in reducing pain and improving range of motion for people who had been experiencing lower back pain for at least three weeks.

"Patients that for one reason or another would prefer osteopathic treatment over medication can confidently choose that alternative," said lead author Gunnar Andersson, M.D., Ph.D., chairman of the orthopedic surgery department at Rush-Presbyterian-St. Luke's Medical Center in Chicago.

McDowell County students visit campus

Five students from Big Creek High School in McDowell County recently visited WVSOM to learn more about medicine and science as part of Educational Talent Search, a federally-funded program administered through Greater Appalachian Outreach, Inc.

Counselor Felicia Oaks explained the purpose of the program is to foster learning and educational aspirations in children who might otherwise not pursue a college education.

"Our goals are to improve a child's class work, encourage the child to finish school, and encourage the child to pursue higher education," said Oaks. "Most of these kids' parents never attended college; 66% of the students enrolled in our program will be first generation college students if they pursue higher education."

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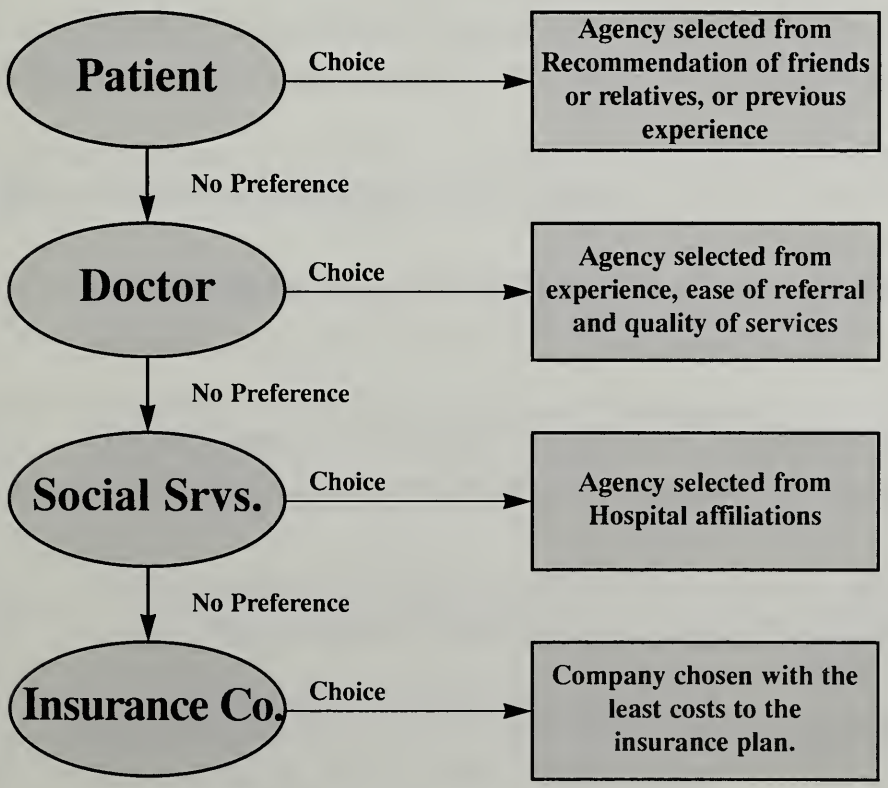
Healthcare — Who's Choice is it?



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Looking back, looking ahead

As the millennium comes to a close, we, in the WVSMA Alliance, look back with gratitude to the people who made the Alliance what it is today.

We are grateful to Mrs. Searle Harris, president of the Woman's Auxiliary to the American Medical Association, for her vision and for helping organize in 1925, a group of physician spouses in West Virginia, now known as the West Virginia State Medical Association Alliance. We were limited to promoting better relations between the medical profession and the public, without any involvement in legislative affairs. The Alliance has progressed remarkably since then.

We are grateful to our past leaders who guided our members towards achieving the goals of the Alliance.

We are grateful to our present leaders for continuing a legacy passed on to them.

We are grateful to our members who made a difference in their own communities through their various health projects.

We are grateful to the WVSMA physicians for their support of our health projects and our mission.

As a new millennium begins, we have new hopes and dreams. And for the remaining months of my term as president of the WVSMA Alliance, I have goals that I hope to complete for the Alliance.

I look forward to another significant increase in membership and more participation among members.

I look forward to a louder, unified voice in support of our physicians in the legislative arena.

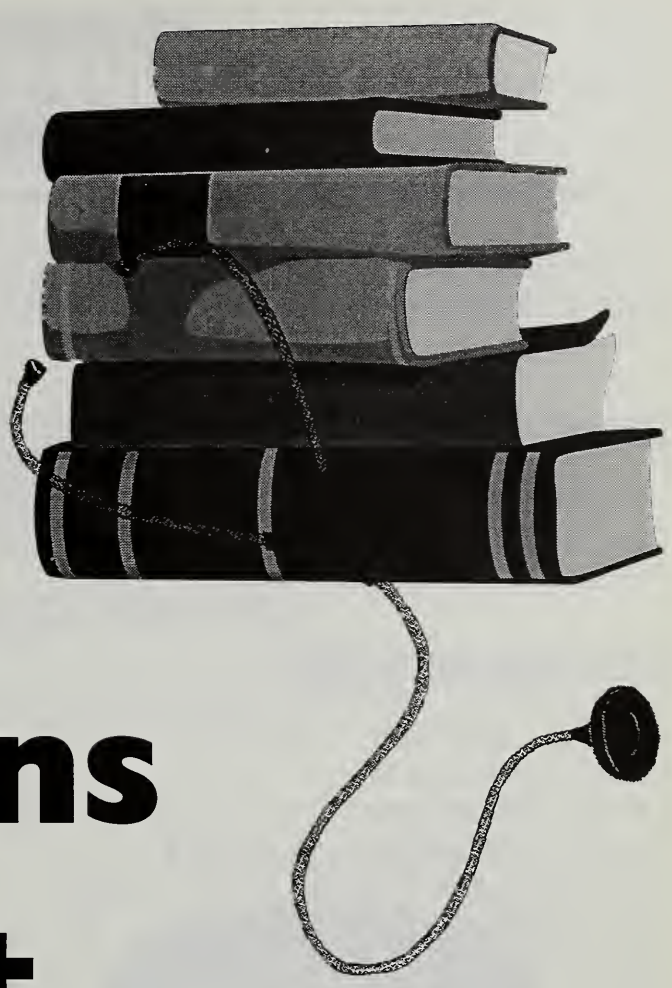
I look forward to continued acceptance and recognition of our SAVE projects and breast cancer awareness program.

I look forward to more successful fund raising for medical research and education.

Love, peace and happiness to you all.

Rose Romero
President, WVSMA Alliance

From one generation of physicians to the next.



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- **Mail checks to Jerry Crites, 2017 Tanbridge Drive, Martinsburg, WV 25401-2916.**
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WESPAC News

We would like to thank these physicians and Alliance members who made the following contributions to WESPAC from July 15 through December 28:

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Obituaries

William Thurlow Booher, Jr., M.D.

Dr. William Thurlow Booher, Jr., 66, of Wellsburg, died at home on Dec. 4.

Dr. Booher was born on Jan. 10, 1933, in Wheeling, son of Mertie Booher and the late Dr. William Thurlow Booher, Sr. He was a graduate of Wellsburg High School and Bethany College. He received his B.S. in medicine from West Virginia University in 1955 and his M.D. from the Medical College of Virginia in 1957.

After completing his internship at Ohio Valley General Hospital in Wheeling in 1958, Dr. Booher began practicing medicine in his hometown of Wellsburg and served as a post surgeon in the XXI Army Medical Corp at Indiantown Gap Military Reservation, Pa. for two years from 1959-61.

Dr. Booher practiced family medicine in Wellsburg and in Brooke County for nearly 40 years, until his retirement in Jan. 1998. He served as Brooke County health officer and coroner for many years, as well as the unofficial team physician for the Brooke County High School football team.

Dr. Booher was recently honored by the Wellsburg Chamber of Commerce as the 1999 Citizen of the Year. At the dinner honoring Dr. Booher, Brooke County Prosecutor David B. Cross said of him, "This citizen followed in the footsteps of his father and his grandfather before him in being a pillar of our community and a faithful servant in the community, providing important help to us.

"He could have chosen to live and work anywhere in the United States. We are all fortunate that he chose to come back to the community where he grew up and to work and raise his family in Wellsburg."

A member of the WVSMA since 1958, Dr. Booher was also a member of the AMA, and a past president of the Brooke County Medical Society. He was a member of the Masonic Lodge 2, A.F. & A.M., Osiris Shrine Temple AAONMS, and the Scottish Rite. He was a former chairman of the Brooke Co. Heart Fund; a past member of the Wellsburg Kiwanis Club and a past member and president of the Brooke Co. Board of Education.

Dr. Booher was active in the Wellsburg Christian Church and served as deacon, elder and past president of the Church board and was a sponsor of the High School Youth Group. He was a member of the Board of Directors and Executive Committee of the Municipal Mutual Insurance Co., Wellsburg. He was a member of Beta Theta Pi national fraternity.

Survivors in addition to his mother, are his wife, June Montgomery Booher; a son, William Thomas Booher and his wife, Beth, of Redwood City, Calif.; three daughters, Gail Larnbie and her husband, Don, of Dublin, Ohio, Karen Strecker and her husband, Brent of Kennewick, Wash., and Lisa Lutz and her husband, Keith, of Kirtland, Ohio; and nine grandchildren.

Memorial contributions can be made to the Brooke Co. Public Library Building Fund, 945 Main St., Wellsburg, WV 26070.

Thomas James Conaty, M.D.

Dr. Thomas James Conaty, 76, died Aug. 21 at St. Mary's Hospital in Huntington.

Dr. Conaty was born in Richmond, Va., in 1922 and then moved to Huntington in 1935. He attended St. Joseph Grade and High School, then received a B.S. degree from the University of Notre Dame in 1944 and served in the U.S. Navy for two years.

Following his military service, Dr. Conaty attended medical school at the Medical College of Virginia, receiving his M.D. in 1952 and returning to Huntington for his internship and residency in obstetrics. He practiced obstetrics and gynecology at St. Mary's Hospital until he retired in 1988. During his career, he served as chief of Ob/Gyn at St. Mary's Hospital for many years.

Dr. Conaty had been a member of the WVSMA since 1955. He was a member of Cabell County Medical Society, St. Joseph Catholic Church, The Knights of Columbus, and Birthright of Huntington.

Dr. Conaty is survived by his wife of 48 years, Eleanor Wolfe Conaty; four sons and two daughters, Mary Kathryn Conaty Leicht and John of Indianapolis, Ind., Thomas James Conaty, Jr. and Mary of Knoxville, Tenn., Michael Griffin Conaty and Ann Marie of Knoxville, Tenn., Brian Patrick Conaty and Deborah of Huntington, Anne Conaty Selvaggi and Kenneth of Huntington, Paul Joseph Conaty and Kathryn of Huntington and 20 grandchildren. He is also survived by a sister, Sr. Marie Therese Conaty of St. Paul, Minn. He was preceded in death by his parents, Mr. and Mrs. Walter J. Conaty; sisters, Mary Conaty Grant, Elizabeth Conaty Spraul and Anna Kathleen Conaty; and brothers, Walter Joseph Conaty, Jr. and Judge Robert Carroll Conaty.

Donations may be made to the St. Joseph High School Building Fund.

David M. Ritchie, M.D.

Dr. David M. Ritchie, M.D., 41, of Charleston, died Dec. 18, as a result of injuries received in a Jackson County car accident.

Dr. Ritchie and his wife, Dr. Caroline Williams, had four young sons, Jonathan, Tristan, Seth and Keaghan. He is remembered by those who knew him, not just for his skills as a physician, but as a devoted father.

Charleston lawyer Ted Kanner said, "Although I knew him as a client, I enjoyed seeing him at baseball games with his kids. "He was a wonderful father, very gentle and caring."

Dr. Ritchie worked actively on the board of directors for the West Virginia Academy of Family Physicians said Executive Director Mike Beller.

"He always kept the academy in the forefront and was a very active member," Beller said. "He was very much a

gentleman, very much the family man. I know he was dedicated to his family. He will be sorely missed."

Dr. Art Rubin, who worked alongside Dr. Ritchie at the former Carepoint Physicians Inc., a subsidiary of Camcare, said "He was a caring and conscientious family physician, well liked by his patients. This is tragic. He was a good person in the community."

Another physician who worked with Dr. Ritchie, Dr. Jeff Ashley, who is now the chairman of the family medicine department at WVU, Charleston Division, said Dr. Ritchie's calm, comforting manner and genuine concern soothed his patients.

Dr. Ritchie was a graduate of Ravenswood High School, West Virginia University School of Medicine in Animal Husbandry and the WVU School of Medicine. He began his medical practice in Big Chimney then moved to South Charleston before locating in Charleston. He was also an emergency room physician at Jackson General Hospital in Ripley and at St. Joseph's Hospital in Parkersburg.

In addition to being a member of the WVSMA, Dr. Ritchie was a member of Kanawha Medical Society and the West Virginia Board of Medicine. He was medical director of Review for Mountain State Blue Cross & Blue Shield and served as "Doc for a Day" during the state Legislature for the past several years.

Dr. Ritchie was a member of Blessed Sacrament Catholic Church in South Charleston and First United Methodist Church in Ravenswood.

In addition to his wife and sons, Dr. Ritchie is survived by his parents, Ray and Peggy Ritchie of Ravenswood; sister, Shelley Ritchie of Washington Crossing, Pa.; brother, S. Douglas Ritchie of Ravenswood; and maternal grandparents, Dr. L.M. and Thelma Monroe of Ravenswood.

Memorial contributions can be made to the Dr. David Ritchie Memorial Fund, c/o Ted Kanner, 1115 Bank One Center, Charleston, WV 25301.

Ralph Waldo Ryan, M.D.

Dr. Ralph Waldo Ryan, 87, of Morgantown, died May 13 at home.

Dr. Ryan was born in Ryan, W.Va., on July 16, 1911. He attended schools in Roane County and graduated from West Virginia University in 1934 with a major in chemistry. He received his M.D. from the University of Michigan Medical School in 1948. Following two years of residency in ophthalmology at Wayne County General Hospital and two more years as a clinical instructor in ophthalmology at the University of Michigan combined with graduate school, he received his M.S. in ophthalmology in 1953.

Dr. Ryan became chief of the Eye Branch of the National Institute of Neurological Diseases and Blindness in 1953 and helped organize its program of eye research. During his two years at the Institute, he did research on the diagnosis and treatment of toxoplasmic uveitis. Later, he worked on and reported about the role of the adenoviruses as a cause of epidemic conjunctivitis and respiratory disease. He also reported on laboratory acquired histoplasmosis as a cause of eye pathology.

When he entered private practice in Morgantown in 1955, Dr. Ryan continued his interest in all fields of eye care and especially in industrial ophthalmology. During his career, he also had a special interest in the socioeconomics of medical care.

A past president of the American Association of Ophthalmology and the West Virginia Academy of Ophthalmology, Dr. Ryan had been a member of the WVSMA since 1956. He served on numerous committees for a variety of other medical associations and was a member of the executive committee of the Better Vision Institute and president of the West Virginia Lions Sight Conservation Foundation. In 1982, Friends of Eye Research presented him with the National Man of Vision Award.

Dr. Ryan was the co-author of the book *Industrial and Traumatic Ophthalmology* in 1964 and of numerous other publications.

Dr. Ryan is survived by his wife, Mary Belle King Ryan; a son and spouse, Walter H. and Dr. Patricia Ryan, of Morgantown.

Donations can be made to: Morgantown Lions Sight Committee, c/o Roy Clarkson, Treasurer, P.O. Box 1072, Morgantown, WV 26507.

Colonel Isaiah A. "Ike" Wiles, M.D.

Colonel Isaiah A. "Ike" Wiles, M.D., died at this home in Morgantown on August 15.

Dr. Wiles was born in Tunnelton, W.Va., in 1908. He received A.B., B.S. and M.S. degrees from West Virginia University and then earned his M.D. from Rush University of Chicago in 1935, where he also completed his internship. He did his residency at the University of Oregon Medical School.

In 1939, Dr. Wiles joined the regular Army Medical Corps and served until 1966, earning the rank of colonel. When he retired from the U.S. Army in 1966, he had received the Bronze Star, the Purple Heart, two Legion of Merit Awards and two Army Commendation Medals. He served an additional 10 years in reserves and in the West Virginia and Illinois National Guards.

Dr. Wiles began working with the Monongalia County Health Department in Morgantown in 1967, and served as health director for Monongalia County until 1978. He was a proponent for West Virginia's public health planning and credited by many as the man who made the Health Department a key component in county government with visibility and notoriety.

As a member of the Scottish Rite which supports language disorder clinics for children, Dr. Wiles helped establish the Monongalia County Clinic in 1994.

Dr. Wiles was selected as the WVU School of Medicine Distinguished Alumnus in 1990. He and his wife, Frances, were regular supporters of alumni and CME activities.

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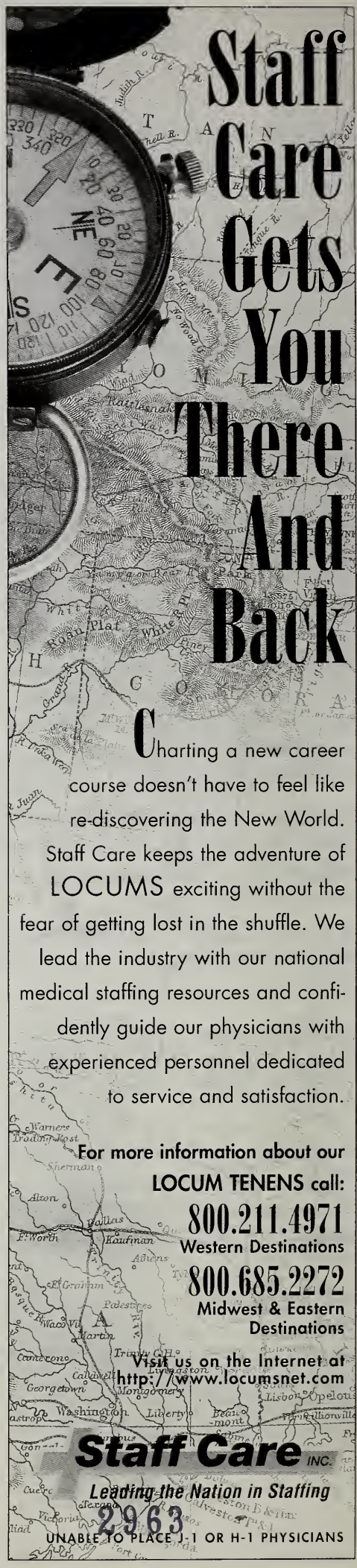

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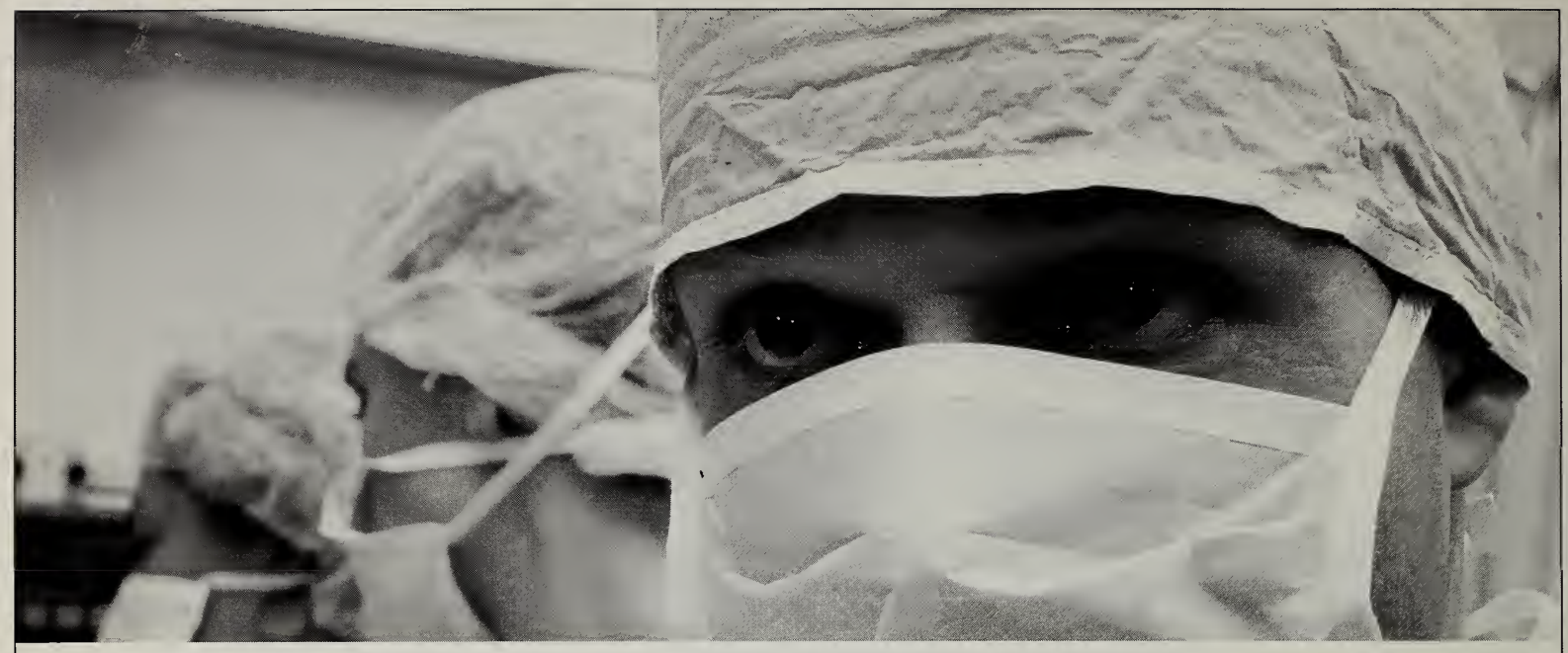

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